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No. 363

children and youth

their Health and Welfare



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A graphic presentation of facts about the health and welfare of children and youth in the United States and of the assistance they received from the Children's Bureau and State and local agencies administering public programs for . . . Maternal and Child Health Services . . . Crippled Children's Services . . . Child Welfare Services

Children's Bureau Publication Number 363

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Social Security Administration • Children's Bureau

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children *and* youth

their Health and Welfare

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MAR 10 1958

Sources

Chart 1. USPHS, NOVS, Health and Demography, October 1956, page 15.

Chart 2. U. S. Bureau of the Census, Current Population Reports, Series P-25, Nos. 98, 121, 123.

Chart 3. U. S. Bureau of the Census, Current Population Reports, Series P-25, No. 123.

Chart 4-5-6. U. S. Bureau of the Census, Current Population Reports, Series P-60, No. 20.

Chart 7-9-10-11-13-14. USPHS, NOVS.

Chart 19. USPHS, Division of Dental Public Health.

All other charts are based on reports made to the Children's Bureau by State health and welfare departments.

foreword

THIS Chart Book presents some important facts as to the environment and background of the children and youth in this country and how these may affect their growing up.

Some of the facts presented in Children and Youth at the Midcentury are brought up to date. The charts also supplement the description of child health and welfare services contained in Your Children's Bureau: Its Current Program.

Most of the facts presented in these charts are drawn from periodic reports to the Children's Bureau by State health and welfare departments. The charts show not only continuing need for service but also some of the progress that has been made toward bettering the conditions of children throughout the country. This was one of the goals defined by the Act of 1912 which established the Children's Bureau. Aid toward reaching this particular goal has been provided to the States under the Social Security Act of 1935.

It is expected that this Chart Book will be useful to health and welfare agencies and to all citizens who are interested in the further development of programs and services for children.

Katherine B. Oettinger

Chief, Children's Bureau

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2. Child population will continue to increase
3. Largest increases in population 1955 to 1965 will be in age groups 10 to 20 years

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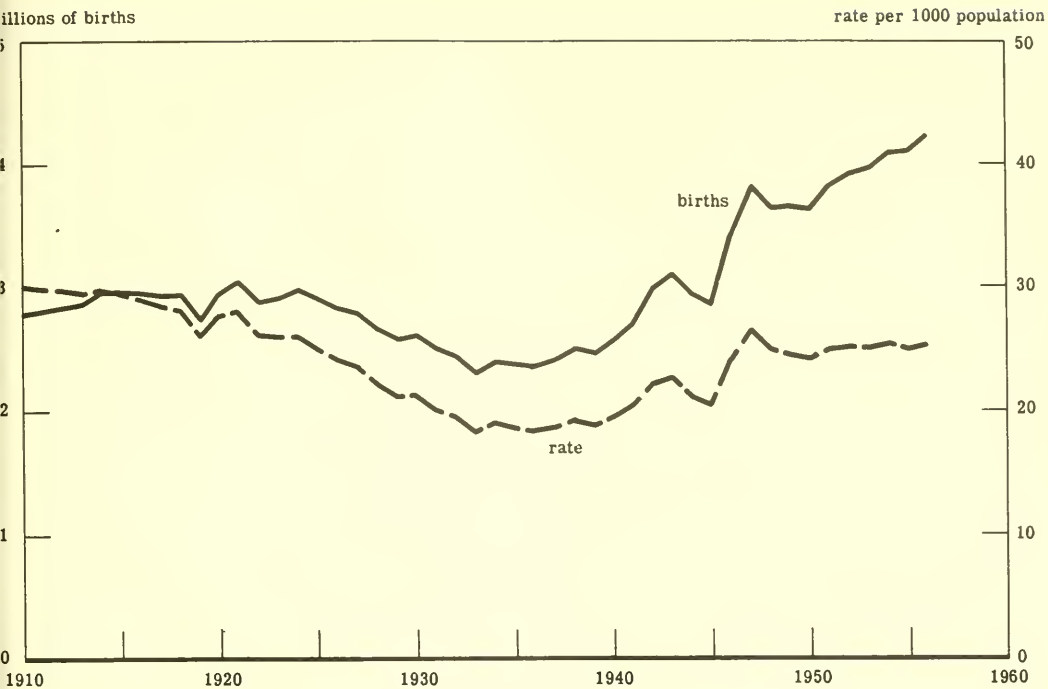
SINCE the great depression of the 1930's, substantial increases have occurred in most years both in the number of births and in the birth rate.

The number of births in 1954 exceeded 4 million for the first time in the history of the United States. Provisional data for 1956 indicate that the total has stayed above 4 million.

Birth rates since the 1930's have also shown increases in most years. Their level during the 1940's and 1950's, however, continues lower than in the second decade of this century.

Data on birth order suggest that families in the United States may also be getting larger. Between 1940 and 1954, birth rates for second, third, and fourth children continued to climb.

BIRTHS CONTINUE TO CLIMB

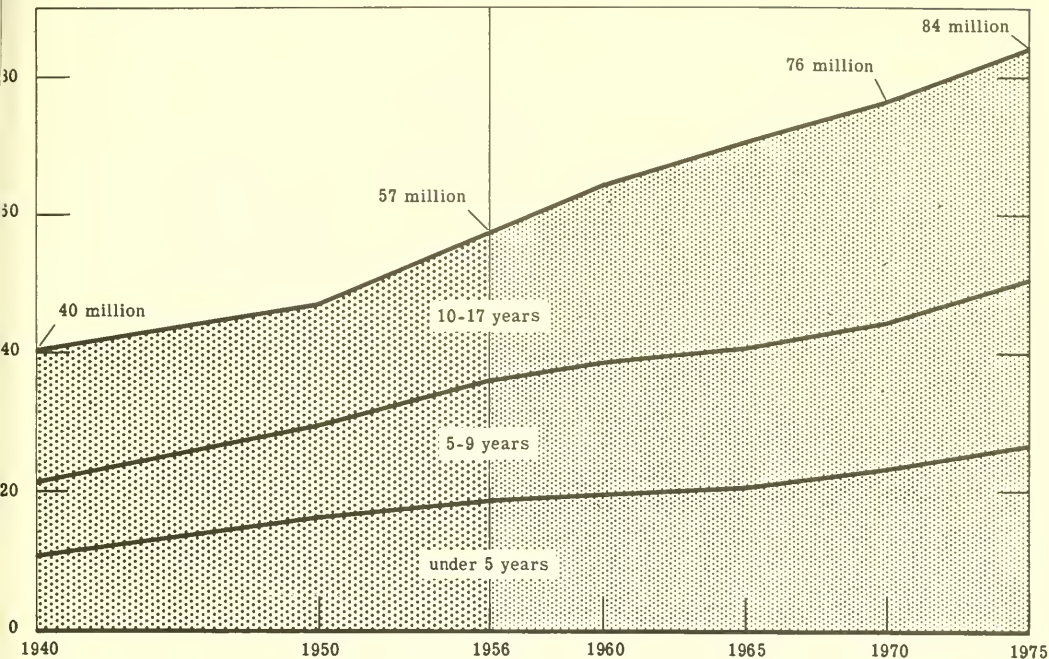


THE number of children in the United States has been increasing not only because of higher birth rates but also because of continued progress in reducing infant and child mortality.

Population experts predict, if present fertility and mortality trends continue, further rise in numbers in each age group under 18 in the next decade or two to: 70 million by 1965, 76 million by 1970, and 84 million by 1975. Children under 18 in 1956 make up a third of the Nation's total population. By 1975, according to this outlook, they will comprise 37 percent of the United States population.

CHILD POPULATION WILL CONTINUE TO INCREASE

millions of children



I

Our Child Population

Chart 2

NUMBERS of children are growing faster than those of aged persons and much more rapidly than numbers of young adults. During the next decade numbers in the groups aged 25 to 34 years will be smaller than in the last decade because of the relatively small numbers of births in the 1930's. Large increases in the groups aged 10 to 20 in 1965 will be the result of the greatly increased numbers of births in the period 1945 to 1955. These changes in the age distribution of the population indicate a relatively small labor force and a relatively large child population.

The ratio of children to adults varies widely from State to State and from farm to urban community. The proportion of children is higher among Negroes than in the white population, higher in the South than in the North and higher in the farm than in the non-farm population.

LARGEST INCREASES IN POPULATION 1955 TO 1965 WILL BE IN AGE GROUPS 10 TO 20 YEARS

estimated population (millions)

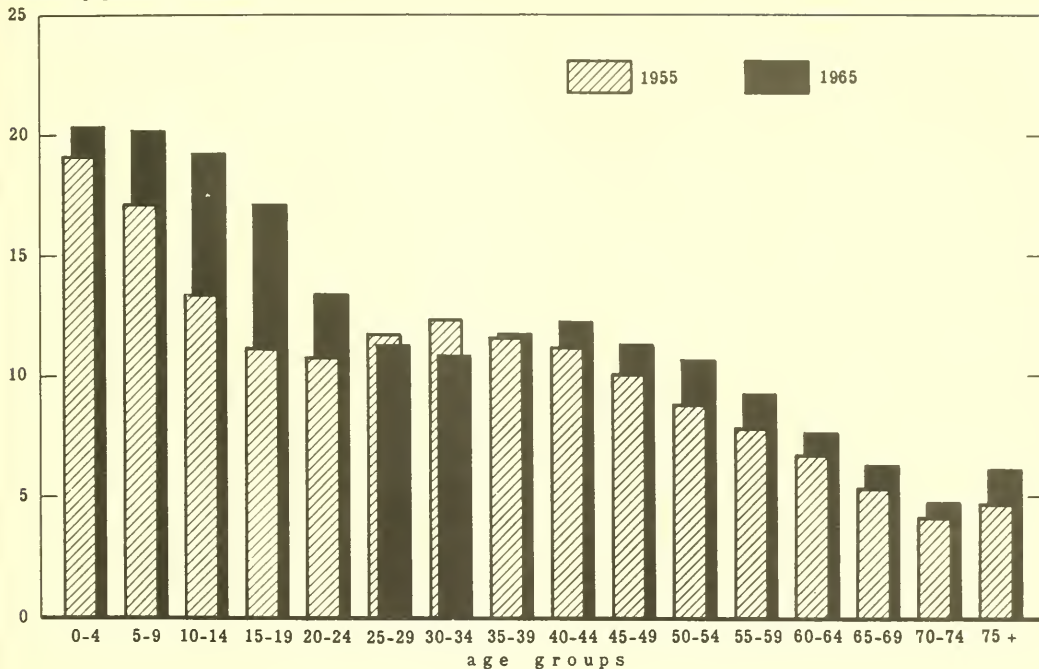


Chart 3

THE Nation's economy has been expanding. Production has reached record levels and employment is high. Most family incomes have been rising. Average family money income is higher than ever before. But some families still have low incomes and millions of children are not sharing in the economic abundance.

Who are the Low Income Families?

▲ Many are families in which the breadwinner is physically or mentally disabled, aged, unskilled or poorly educated.

▲ Many are the families of share-croppers, hired farm workers and migratory farm laborers.

▲ Many live in depressed areas, geographic pockets where chronic unemployment is high.

▲ Many are broken families headed by a mother who must remain at home to care for her children or by a mother who earns little because she is unskilled.

▲ Many, a disproportionate number, are Negro.

▲ Many must depend entirely on income from public assistance or old age and survivors insurance.

Not all of these families have children but two groups, farm families and non-white families, have more than average numbers of children, less than average income.

The average income in 1954 of families headed by a woman was only \$2,294. About 4 million children lived in such families.

By 1955 average family money income had increased by 6 percent to a new high level of \$4,840; farm families averaged \$2,131.

AVERAGE FAMILY-INCOME IN THE UNITED STATES IS HIGHER THAN EVER BEFORE

But some families still have low money incomes

United States
average

\$4,173

INCOMES ARE LOW IN:

nonwhite
families

\$2,410

broken
families
headed by
a woman

\$2,294

farm
families

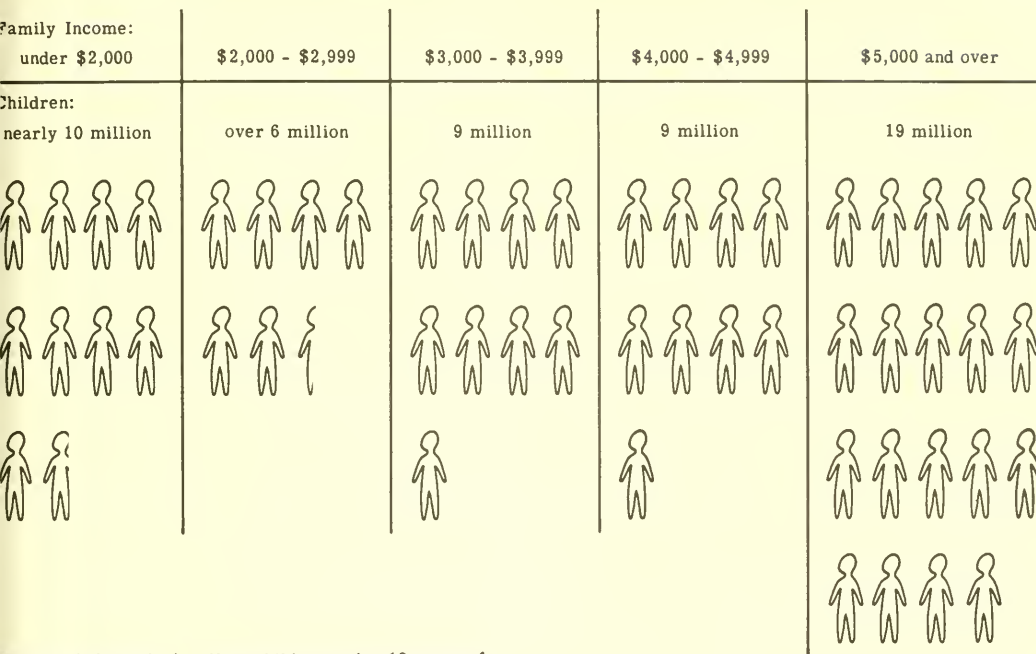
\$1,973

median annual family money income, 1954

AT LEAST 26 million children in 1954 were in families whose money income was less than \$4,173, the average for the United States.

Out of every 100 children, 47 were in families with less than \$4,000; of these, 18 were in families with less than \$2,000 a year.

OVER ONE-SIXTH OF THE NATION'S CHILDREN IN 1954 WERE IN FAMILIES WITH INCOMES OF LESS THAN \$2,000 A YEAR



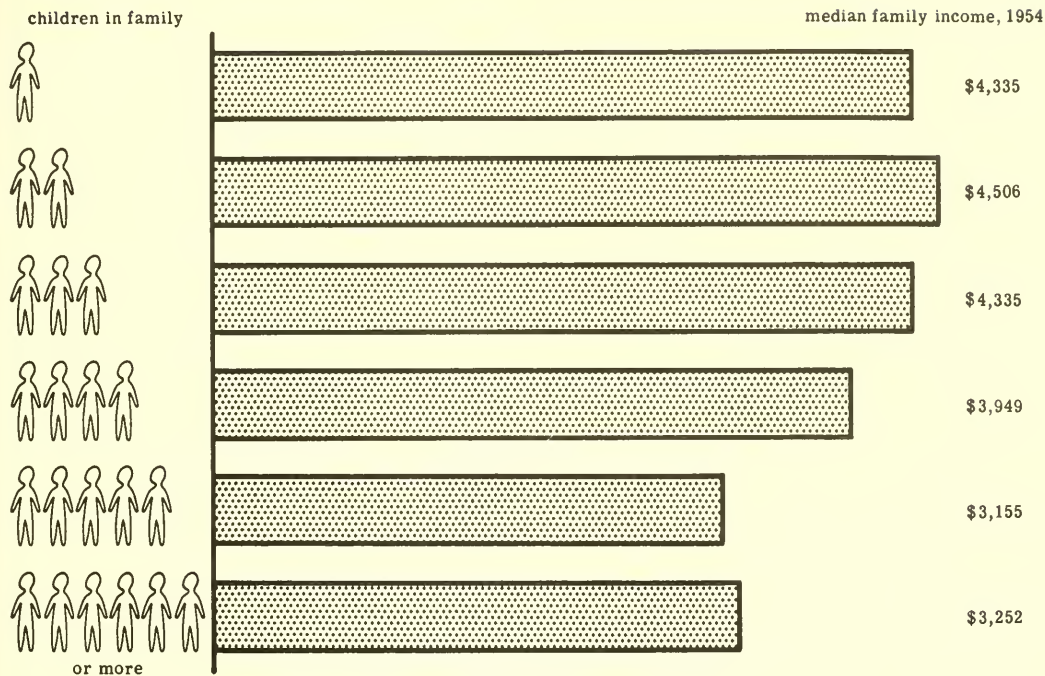
each symbol equals 1 million children under 18 years of age

MOST of the Nation's children are in a relatively small proportion of its families. Families with 3 or more children constitute only 18 percent of all families but they have 54 percent of the country's children.

In general, large families are not as well off financially as small families. Families with 3 children had an average income in 1954 of \$4,335, which exceeded the national average family income of \$4,173. But the average income of families with 4 children was \$3,949; families with 5 children, \$3,155; and families with 6 or more children, \$3,252.

Families with no children had an average income of \$3,929.

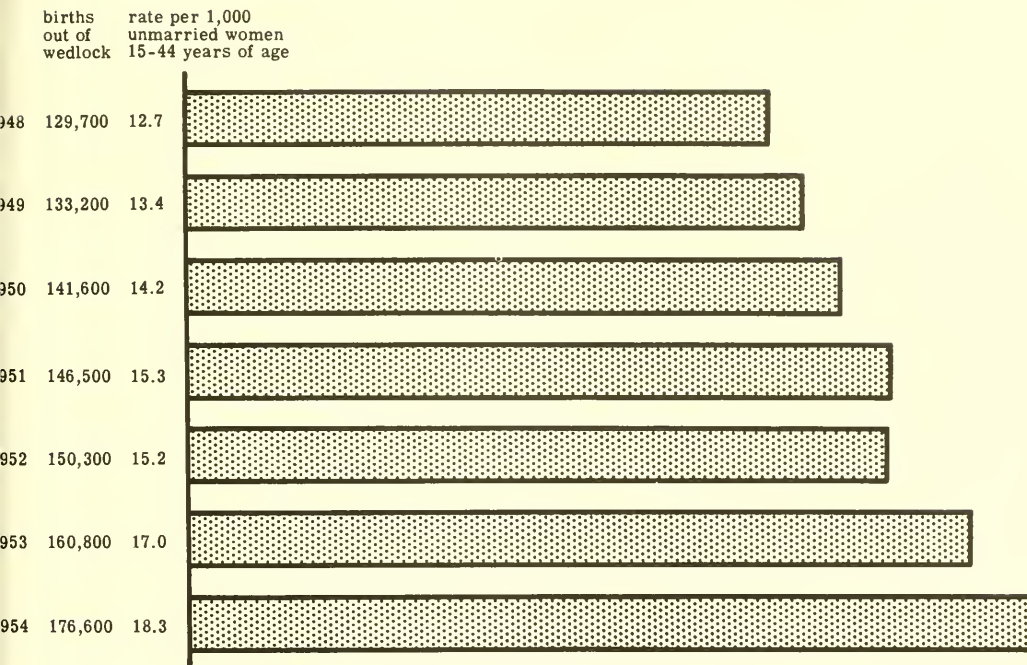
MOST LARGE FAMILIES HAVE LOWER INCOMES THAN SMALL FAMILIES



N EARLY twice as many children were born out of wedlock in 1954 as in 1939. Rates per 1,000 unmarried women aged 15-44 years have increased steadily from 13 in 1948 to 18 in 1954.

Close to 2 out of 3 births out of wedlock in 1954 were to nonwhite mothers. Many of the unmarried mothers were children themselves; 37,500 were under 18 years of age.

BIRTHS OUT OF WEDLOCK ARE INCREASING

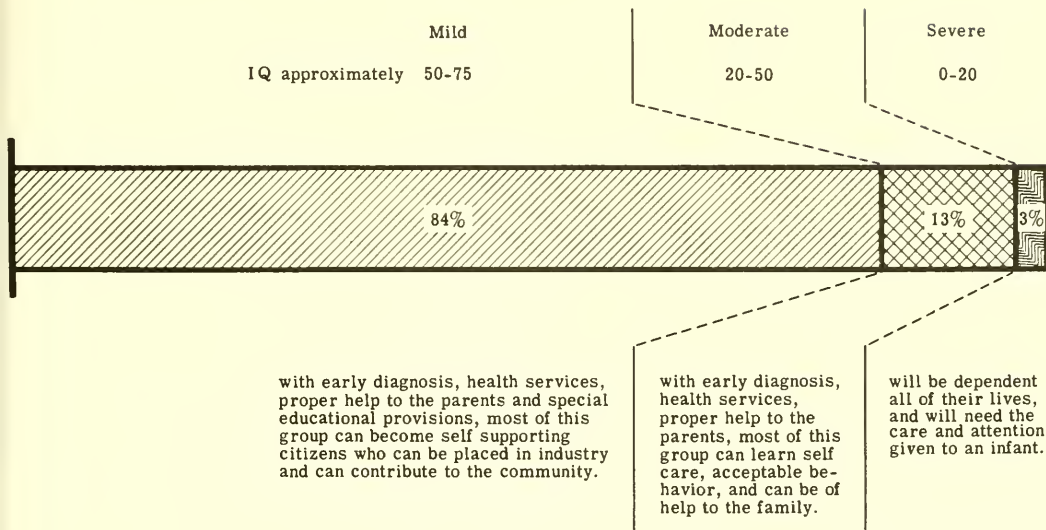


NO ONE knows how many children are mentally retarded because not all come to the attention of educational, health and social agencies and diagnosis is difficult. On the basis of a few studies it has been estimated that for every 100,000 persons in the general population 3,000 are mentally retarded.

The great majority have such potentialities for development that with early diagnosis and proper help most mentally retarded children can become self-supporting citizens.

DEGREE OF MENTAL RETARDATION VARIES WIDELY

It is estimated that 3 percent of the total population have an intelligence quotient of 75 or less, but the potentialities within this group are large



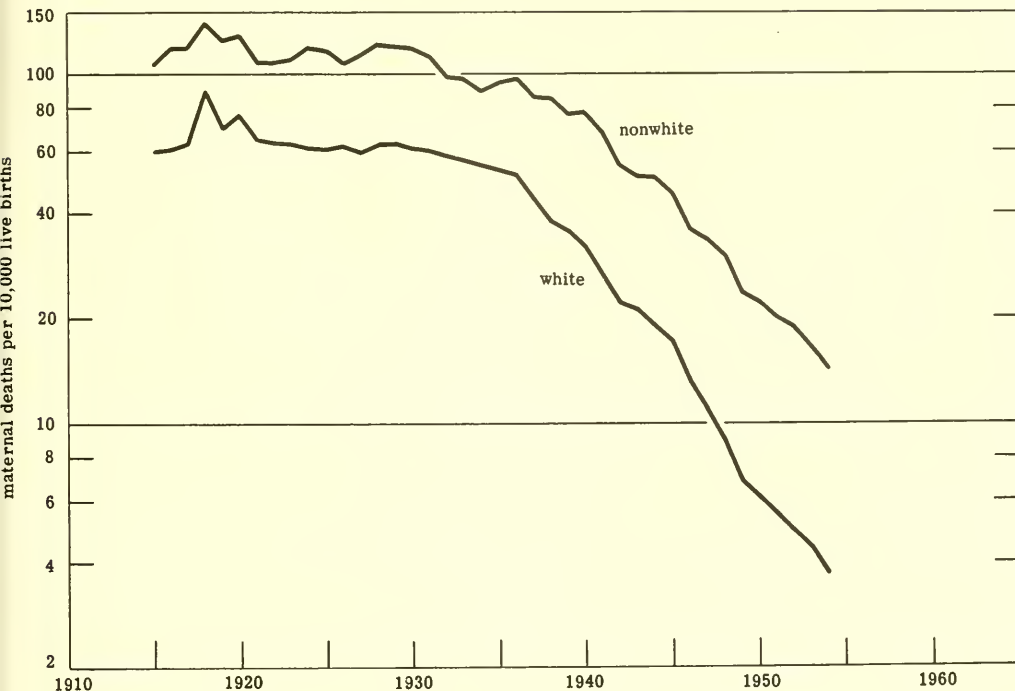
IN 1954, 2,105 women died in the United States from complications of pregnancy, childbirth, and the puerperium. The maternal mortality rate was 5.2 per 10,000 live births, the lowest ever recorded in the United States.

In the past decades, the largest gains in saving the lives of mothers have been made in metropolitan counties, that is in counties with at least one city of 50,000 or more population. An isolated county is one that is not metropolitan, nor adjacent to a metropolitan county. In some of these, excessively hazardous conditions still take mothers' lives needlessly.

Progress in reducing fatal risks to nonwhite mothers lags about a decade behind gains for white mothers.

GREAT ADVANCES IN THE BATTLE AGAINST MATERNAL MORTALITY HAVE BEEN MADE

But the smallest gains have been among nonwhite mothers

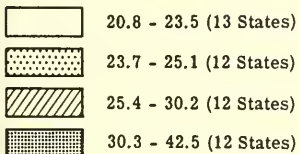


INFANT mortality in the United States has dropped spectacularly from the high figures prevalent early in this century. But in some States, particularly in the South and Southwest, renewed efforts are needed to save the lives of babies in their first year.

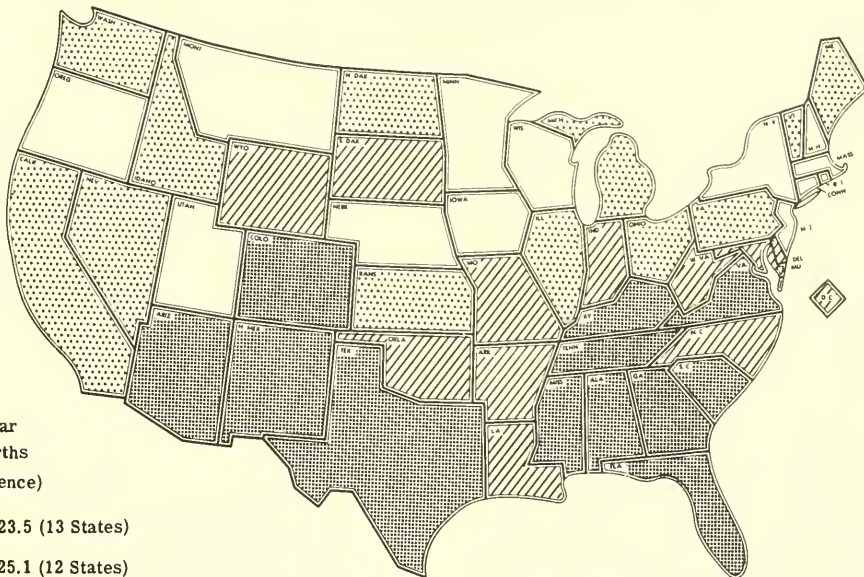
In many States infant losses are needlessly high in the counties isolated from large urban centers. About 30 percent of all babies born alive in the United States are in such counties, where the infant mortality rate is 27 percent higher than in metropolitan areas.

INFANT MORTALITY RATES ARE STILL HIGH IN SOME STATES

deaths under 1 year
per 1,000 live births
(by place of residence)



average 26.6
median 25.1



III

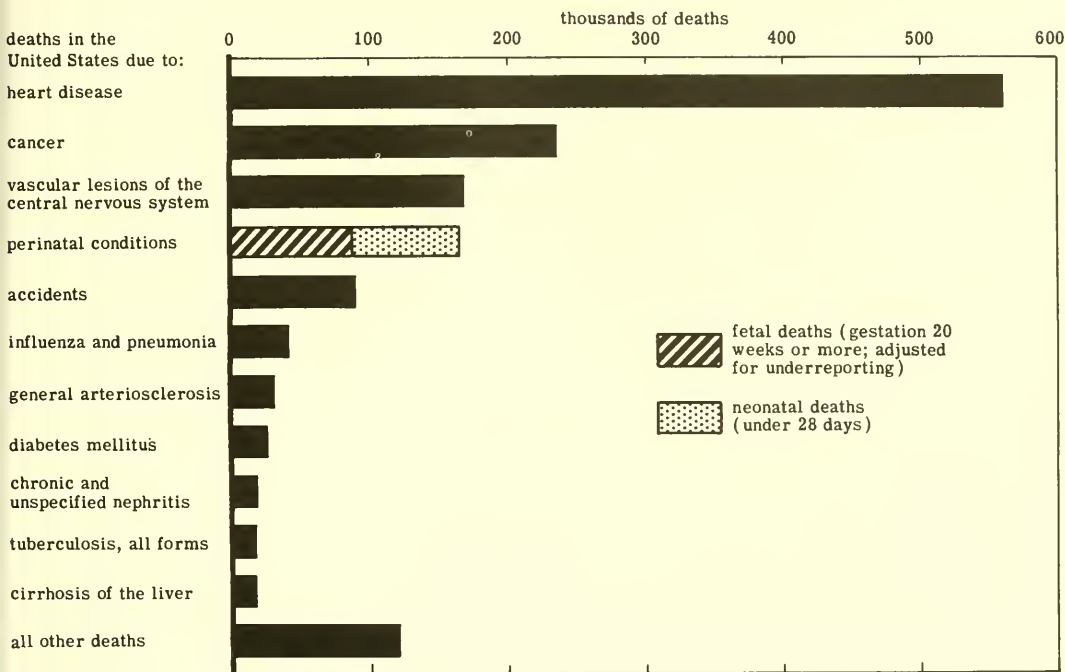
Health Problems of Children

Chart 10

MORTALITY connected with being born has declined in the United States. However, in 1954, fatalities to infants before, during and just after birth were estimated at 164,000. Such deaths were exceeded only by deaths at all ages from heart disease, cancer, and cerebral hemorrhage or other cardiovascular conditions. They constituted about 10 percent of the total mortality at all ages in the United States in 1954.

Infant losses before and during birth are about five times as large as the number of deaths from tuberculosis at all ages, about as large as deaths from all kinds of accidents in the United States.

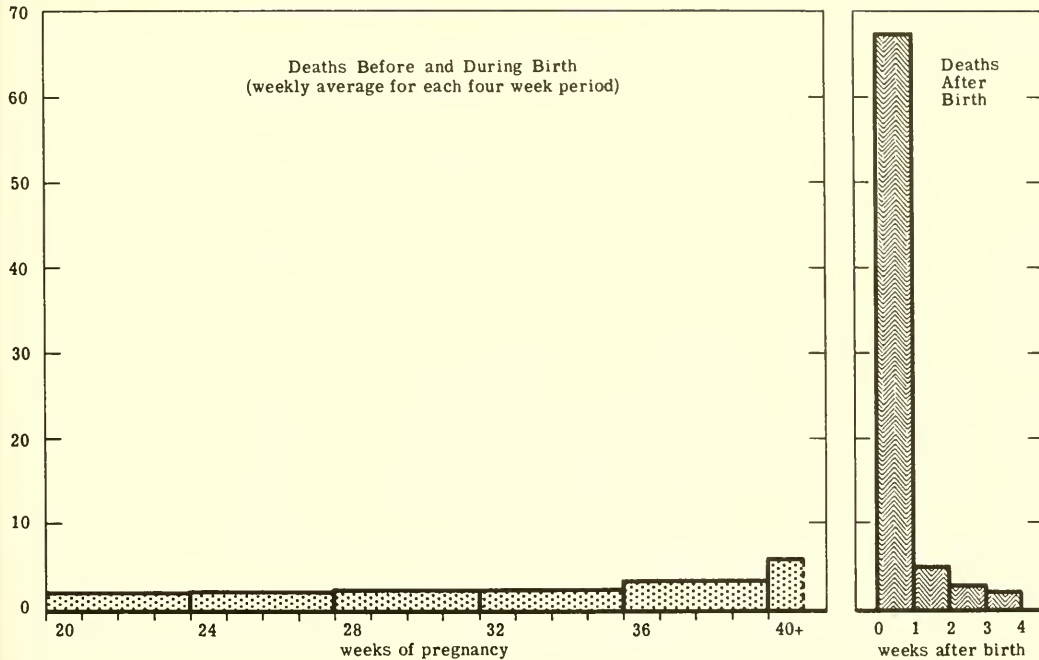
PERINATAL DEATHS ARE EXCEEDED ONLY BY DEATHS FROM HEART DISEASE, CANCER AND VASCULAR LESIONS OF THE CENTRAL NERVOUS SYSTEM



PERINATAL mortality comprises the deaths, annually, of some 147,000 infants whose mothers' pregnancies reached 20 weeks or more. Nearly half of these babies die before or during birth, while 76,724 were reported in 1954 as live born infants who died in the first month of life. The chart shows the number who died in each week of pregnancy and the number who died in each of the first 4 weeks after birth.

RISKS TO BABIES ARE GREATEST AROUND BIRTH

thousands of deaths



III

Health Problems of Children

Chart 12

N EARLY 9 out of 10 deaths in the neonatal period occur in the first week of life. The majority of these infants who fail to survive are born to mothers whose pregnancies do not run to normal term. In many cases the reason for the premature termination of pregnancy is unknown.

About 80 percent of the mothers whose babies weigh 2,000 grams or less (that is, less than four and a half pounds) at birth are unable to continue their pregnancies as long as 37 weeks.

PREMATURITY IS THE LARGEST SINGLE CAUSE OF NEONATAL DEATHS

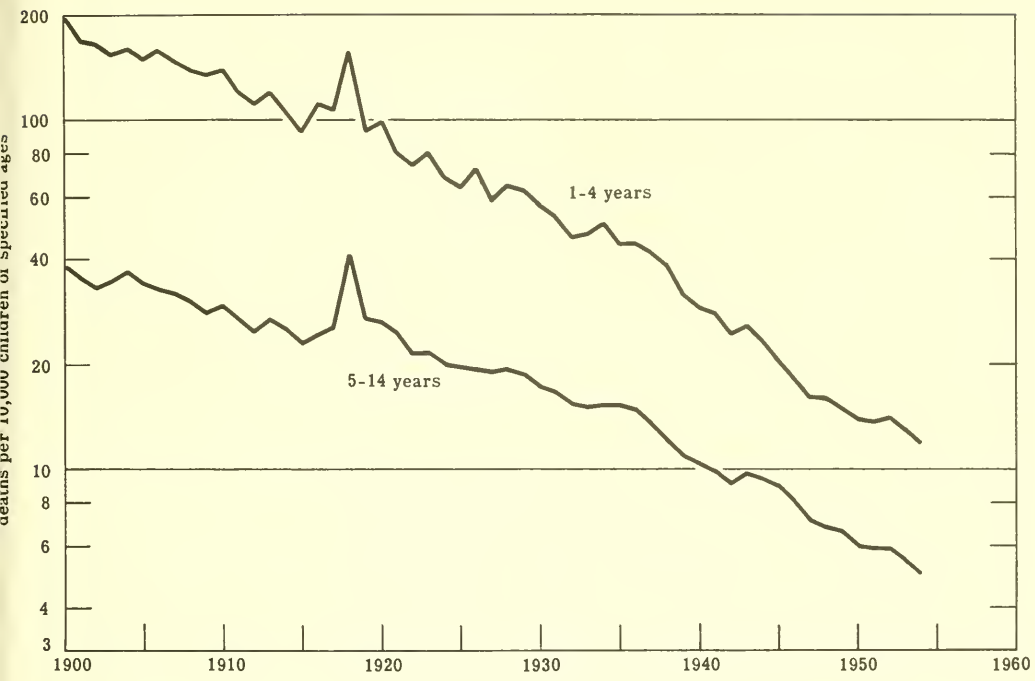


Chart 13

THE infant who has reached his first birthday in the United States has a good chance of life—among the best chances in all countries of the world today of reaching eighteen. But there are still many deaths in childhood that are preventable. Since medical science has won many victories over disease, accidents have become the top cause of death among children of pre-school and school age and young adults.

Next in importance to accidents as causes of death for children 1-4 years of age are influenza and pneumonia, congenital malformations and cancer. For the 5-14 year age group next to accidents are cancer and congenital malformations.

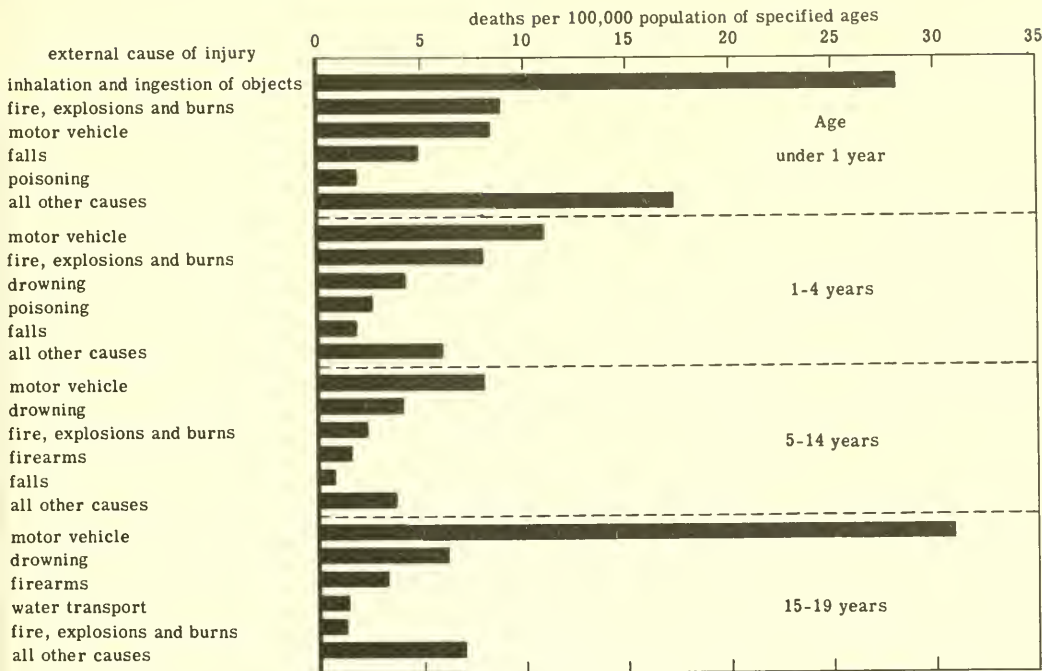
DEATHS OF CHILDREN AFTER INFANCY ARE DECLINING SHARPLY



ACCIDENTAL deaths are now the leading cause of death for children aged 5-19 years. Those resulting from motor vehicles are the most numerous. Even for infants under 1 year, motor vehicles in 1954 caused 8 deaths per 100,000. For this age group, however, more accidental deaths resulted from fire, explosions, burns and inhalation or ingestion of objects.

Deaths from accidents are largely preventable. Community health agencies must meet this challenge with bold new programs of education of the people to reduce accidents to children.

MOTOR VEHICLES CAUSE LARGEST NUMBER OF ACCIDENTAL DEATHS TO CHILDREN



MATERNAL and child health programs with the aid of Federal funds are operating in all States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands. Services available to mothers and children are not the same in all States, since each program is planned by the State to meet its particular needs. State programs also vary in geographic coverage; some services are State-wide; others are limited to certain areas in the State.

During the past two decades Federal grants-in-aid have enabled States to provide services to more expectant mothers at maternity clinics and to more infants and young children at child health clinics. The gain is also substantial even in proportion to the numbers of births and the size of the infant and child population. Physical and emotional growth of infants and children and parent-child relationships have received increasing recognition under the program.

THE NUMBER OF MOTHERS AND CHILDREN ATTENDING CLINICS UNDER THE MATERNAL AND CHILD HEALTH PROGRAMS HAS INCREASED

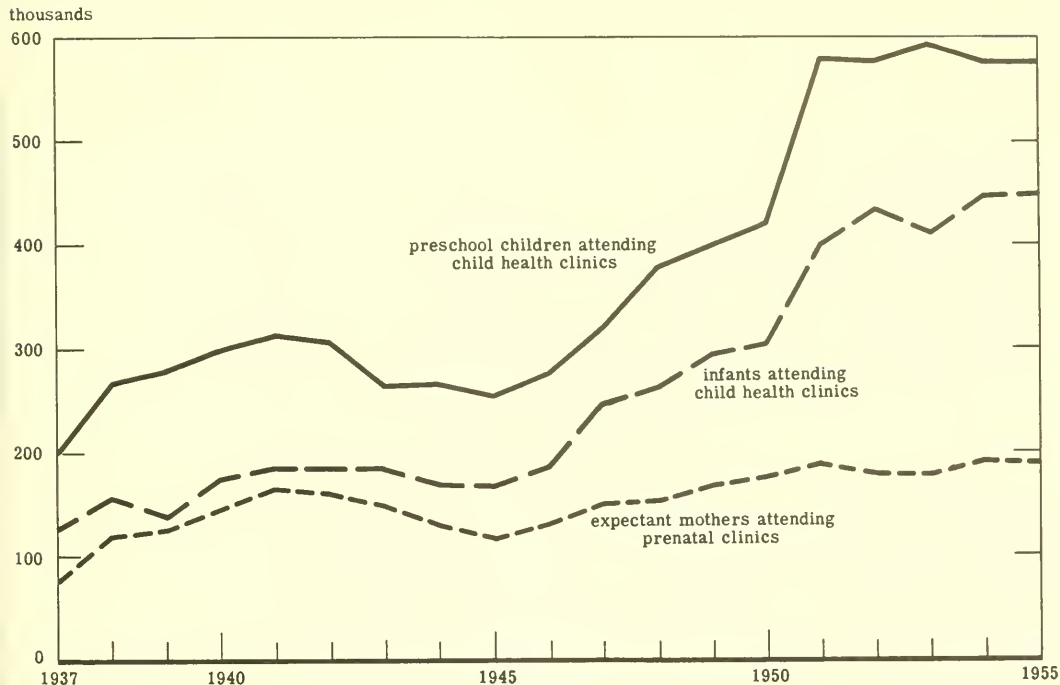


Chart 16

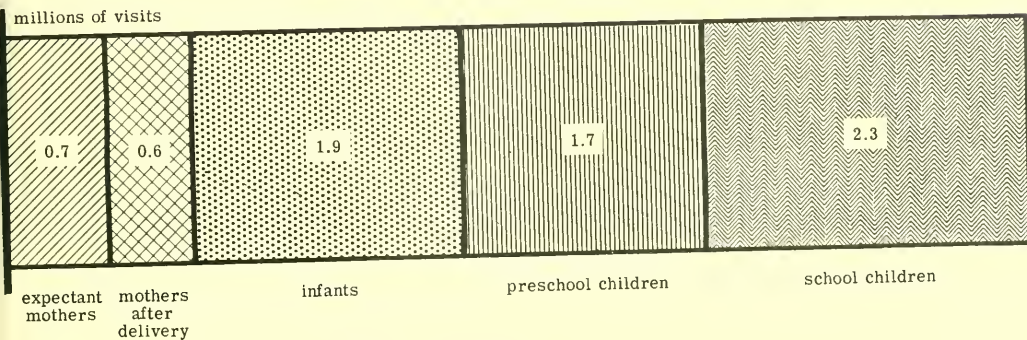
PUBLIC health nurses of State and local health agencies make almost 7 million visits a year to mothers and children. Of these visits one-third are for school children. School health service has remained the largest single nursing service under the maternal and child health program since 1937.

Almost 700,000 preschool children and 700,000 infants receive service by public health nurses.

Maternity nursing service is also an important aspect of the maternal and child health program. About 250,000 expectant mothers are visited in a year by public health nurses and about 300,000 women receive nursing service in the postpartum period following delivery.

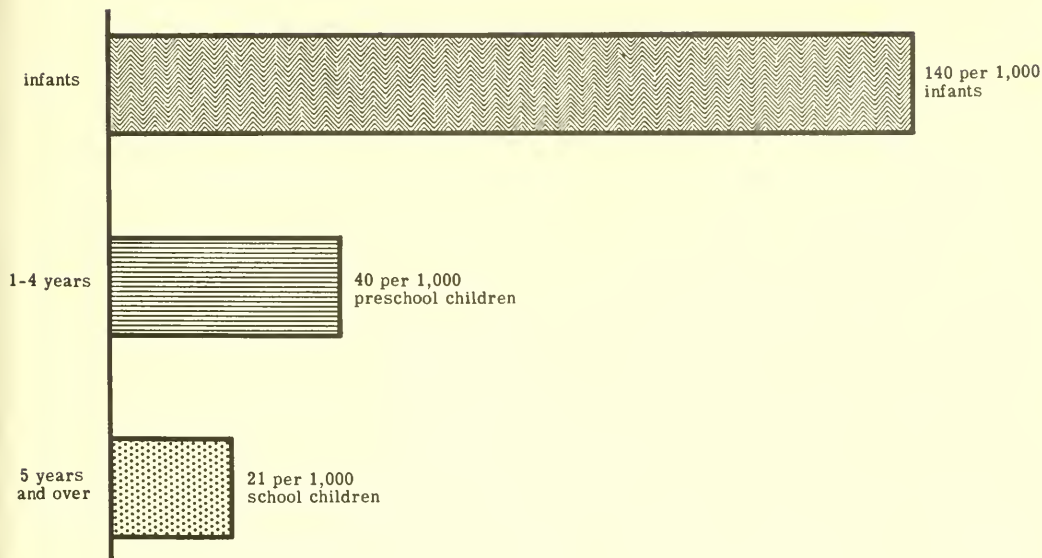
In addition, an unknown number (no doubt many millions) of visits are made by nurses in voluntary health agencies and in city health departments which are not reported by the State agency.

EACH YEAR MILLIONS OF VISITS ARE MADE BY NURSES IN STATE AND LOCAL PUBLIC PROGRAMS TO IMPROVE THE HEALTH OF MOTHERS AND CHILDREN



IN 1955 about 14 percent of the number of infants born during the year were given diphtheria immunizations through the State health agencies, compared with about 7 percent a decade earlier. Maternal and child health services continue, however, to provide immunization to children who missed this service in infancy. Approximately 3 percent of preschool and school children were given such immunizations in 1955. Over 900,000 diphtheria immunizations, about half of those given by State and local health agencies, were for children aged 5 years and over.

MORE CHILDREN ARE NOW RECEIVING DIPHTHERIA IMMUNIZATIONS IN INFANCY



ARTIFICIAL fluoridation began with the public water supply of Grand Rapids, Michigan, in 1945. This first program proved so successful in reducing tooth decay in children that over 1,000 communities are now adding fluorides to their water supply. In addition to the 22,000,000 people living in these communities, 3,500,000 live in areas with water containing natural concentrations of fluorides that give maximum protection.

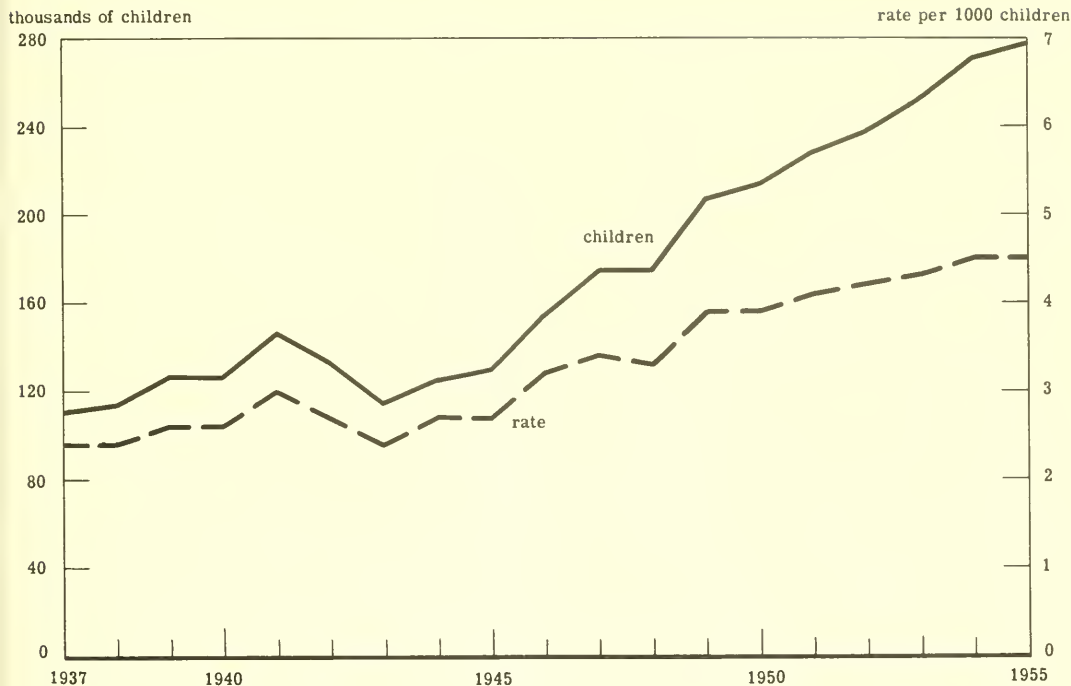
Local water fluoridation is one of the means of improving the dental health of children which is being emphasized today by Federal and State health agencies. Other means are topical application of sodium fluoride and the encouragement of dental treatment.

THE NUMBER AND POPULATION OF FLUORIDATED AREAS
HAVE INCREASED TREMENDOUSLY



SINCE the establishment of grants-in-aid to the States for care of crippled children under the Social Security Act the growth in crippled children's programs has been striking, particularly in the post-war period. In 1955, the total number of children served was almost two and one-half times as great as in 1937, and the number served per 1,000 children in the population almost doubled. Despite this increase, however, many handicapped children still need medical rehabilitation. For example, some 675,000 children are estimated to have rheumatic fever; only 1.4 percent of them are under official programs. Children with cerebral palsy probably number around 300,000; only about 8 percent are in the State and local programs. Roughly 295,000 children are affected with epilepsy; less than 1 percent are assisted by the crippled children's services.

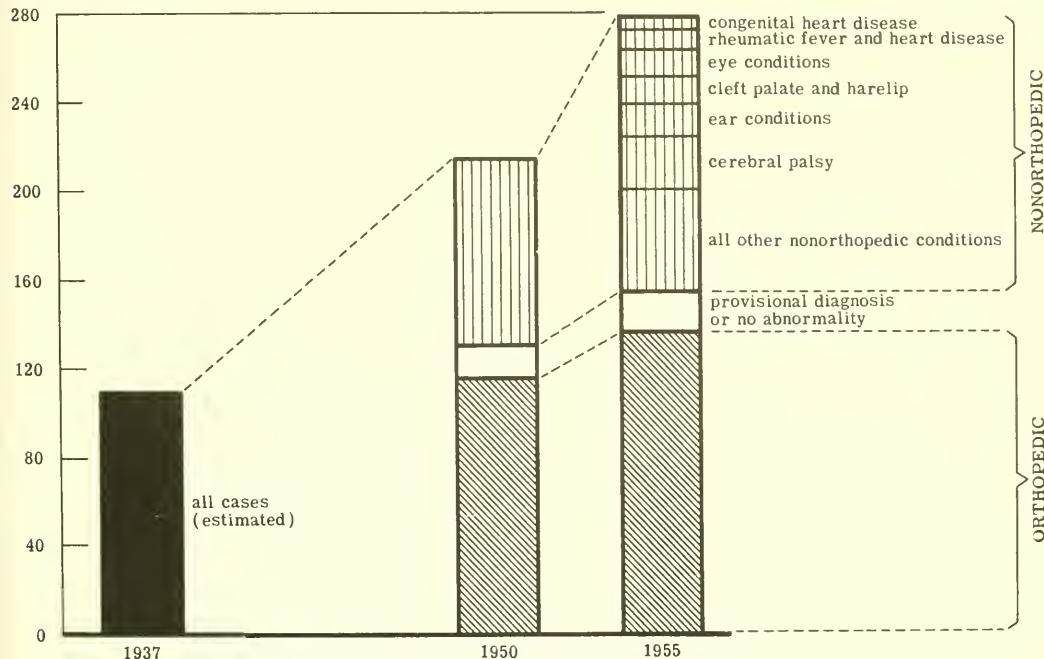
SERVICES TO HANDICAPPED CHILDREN UNDER THE CRIPPLED CHILDREN'S PROGRAMS HAVE RISEN SHARPLY



IN THE beginning, the great majority of children served by the crippled children's program had orthopedic or plastic conditions. Now the scope of crippled children's services is being extended more and more to include nonorthopedic conditions. Recognition that children can be handicapped by diseases and conditions other than orthopedic is only one of the factors responsible for this trend. Development of new drugs, such as antibiotics and anticonvulsants, has given new hope for the successful treatment of many handicapping conditions. Marked advances in types and techniques of surgery are also responsible for expansion in cases of congenital heart disease.

CRIPPLED CHILDREN'S PROGRAMS INCLUDE AN INCREASING PROPORTION OF CHILDREN WITH NONORTHOPEDIC CONDITIONS

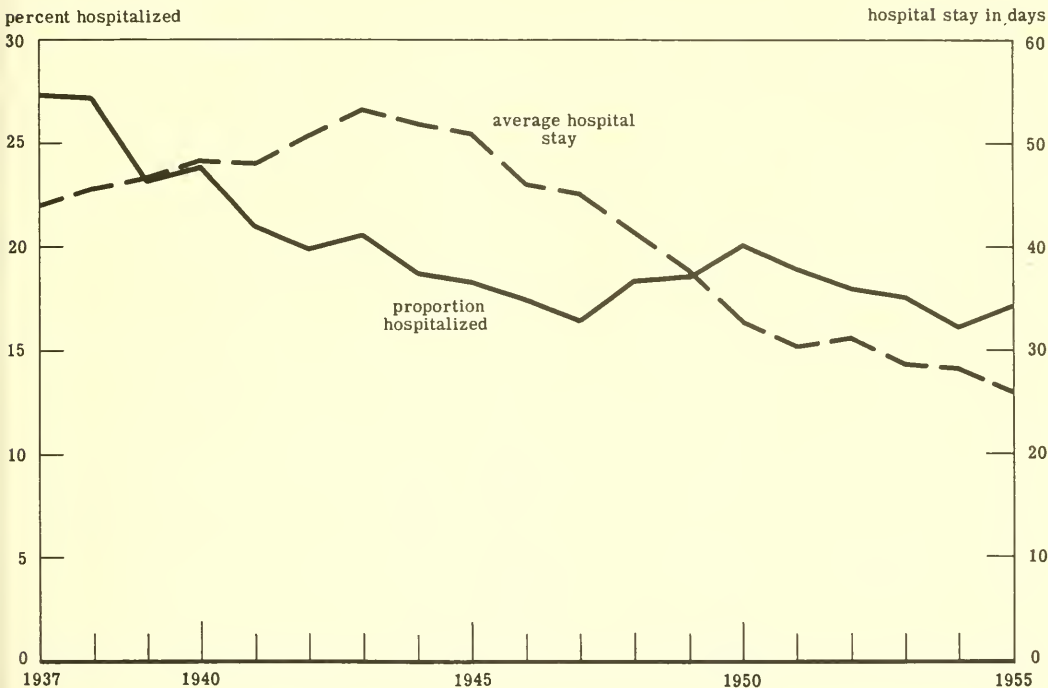
thousands of children



THE proportion of children in the programs who are hospitalized is on the decline, although, as the programs grow, larger absolute numbers of children are receiving hospital services today than in 1937. In that year, more than one among four children was hospitalized; now, one of six receives such care. Length of stay is also shorter.

Rising costs of in-patient care have been important, though not the only factor, in the increased cost of care for crippled children, since hospitalization constitutes a major item of total disbursement. Data collected by the American Hospital Association show that expenses per patient day in general and in special non-profit, short-term hospitals rose, on the average, from \$8.95 in 1945 to \$24.15 in 1955.

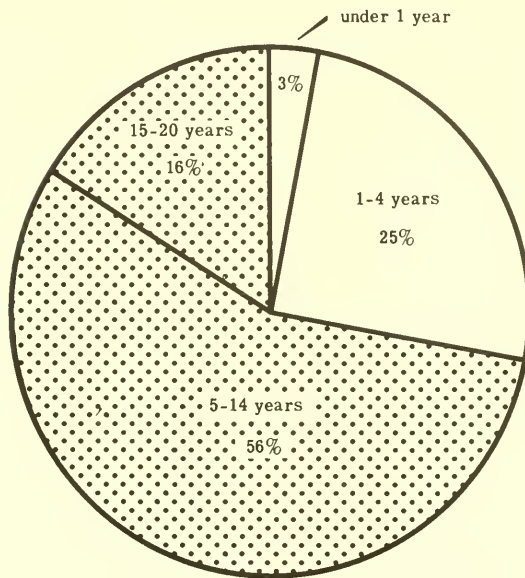
SMALLER PROPORTIONS OF CHILDREN UNDER THE CRIPPLED CHILDREN'S PROGRAMS ARE BEING HOSPITALIZED AND THE STAY IS SHORTER



N EARLY three quarters of the children served in the crippled children's program are of school age. In relation to population of the same age the group aged 5-14 years is the largest, 5.2 per 1,000, and the infant group is smallest, 2.2 per 1,000. Children aged 1-4 years in the program constitute 4.6 per 1,000 of the same age in the general population; those 15-20 years are 3.4 per 1,000.

In the pre-school group larger proportions of nonwhite children than white children are reached by the program; in the school age group the reverse is true. Among conditions for which handicapped children receive service, cleft palate and harelip are most frequent among infants, congenital clubfoot among pre-school children, late effects of poliomyelitis in the group 5-14 years and effects of accidents in the group 15-20 years.

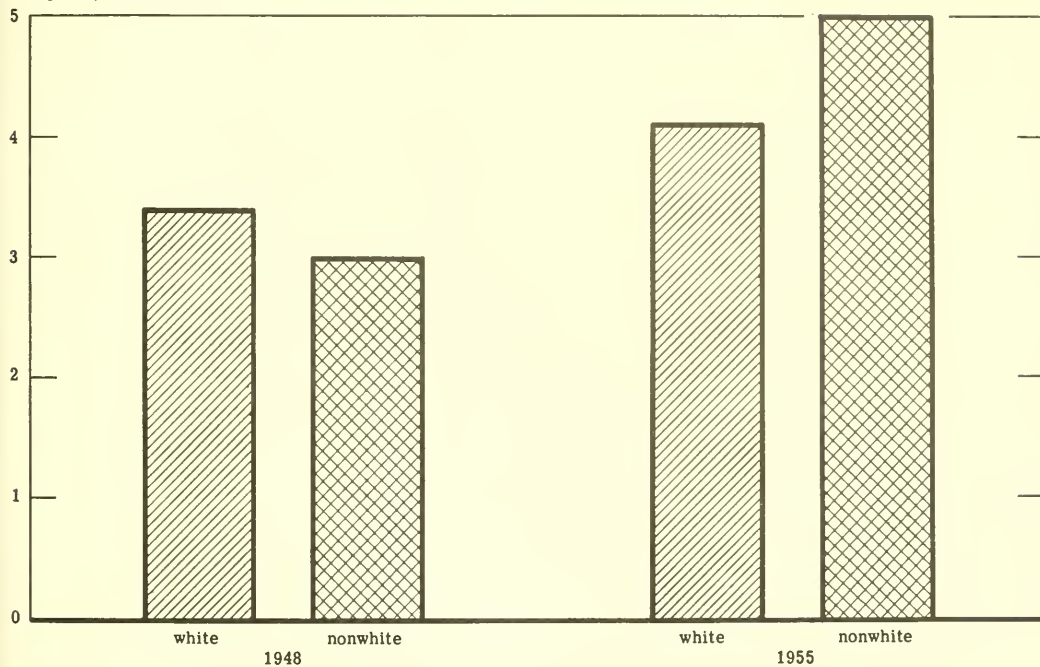
SCHOOL AGE CHILDREN PREDOMINATE IN THE CRIPPLED CHILDREN'S PROGRAMS



THERE are more white children than nonwhite in the crippled children's program but the proportion of nonwhite children in relation to the child population is greater. In 1954 the rate for nonwhite children in the program was 5.1 per 1,000 children in contrast with 4.2 per 1,000 for white children. The reverse was true in 1948 when the rate for white children was slightly higher (3.2) than that for nonwhite children (2.9).

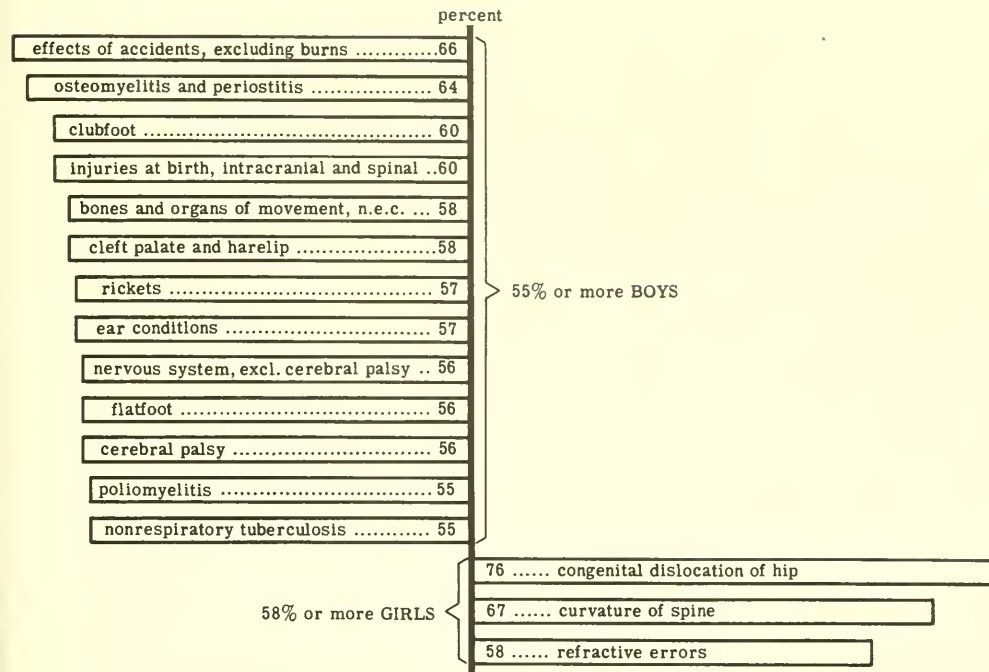
RELATIVELY MORE NONWHITE CHILDREN ARE NOW BEING REACHED FOR SERVICE IN THE CRIPPLED CHILDREN'S PROGRAMS

rate per 1,000 children



BOYS outnumber girls in the crippled children's program. For the country as a whole 55 percent of the children served are male and 45 percent female. The highest sex differentials are found for accidents among boys, and for congenital dislocation of the hip among girls. These differentials in services are consistent with sex differences in the prevalence of the handicapping conditions.

FOR MOST CONDITIONS MORE BOYS THAN GIRLS RECEIVE CARE UNDER THE CRIPPLED CHILDREN'S PROGRAMS

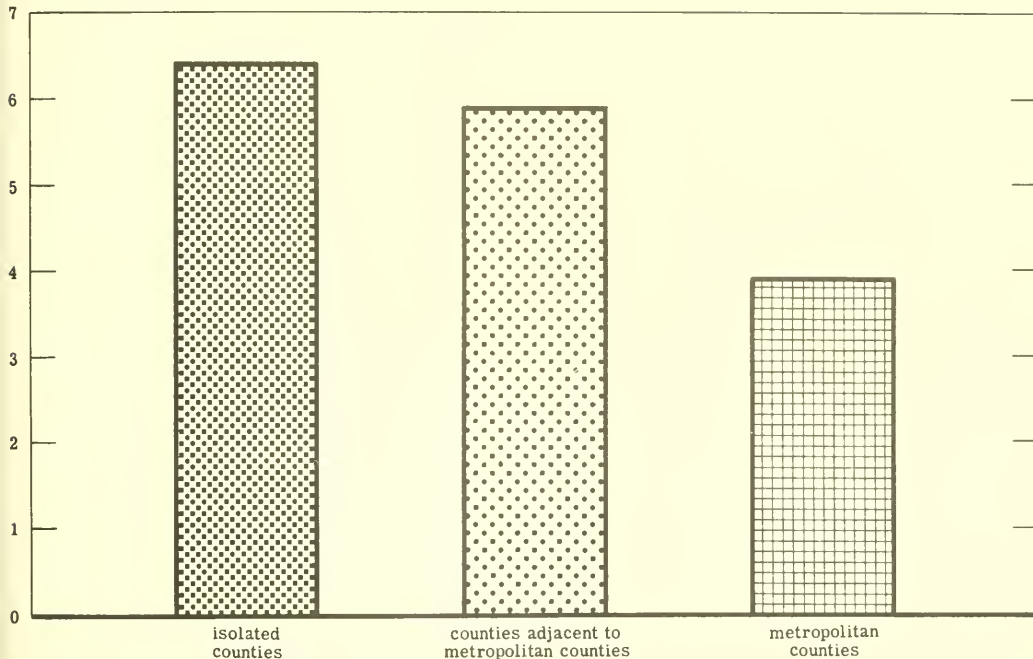


AMONG the major objectives of the crippled children's program are extension and improvement of services for handicapped children in areas where funds and facilities are least available.

In the general population about 36 percent of all children live in counties isolated from metropolitan areas, as against nearly half (48 percent) in metropolitan counties (those including cities of 50,000 or more) and 16 percent in counties adjacent to metropolitan counties. The distribution of crippled children served under the program is about equal for metropolitan and isolated counties—around 40 percent. The remainder (20 percent) come from counties adjacent to metropolitan areas. When children served under the program are related to the population under 21, however, we find that children in isolated counties are served at a rate well over one and one half times as great as children living in metropolitan counties.

THE CRIPPLED CHILDREN'S PROGRAMS REACH RELATIVELY MORE CHILDREN LIVING IN ISOLATED COUNTIES

rate per 1,000 children



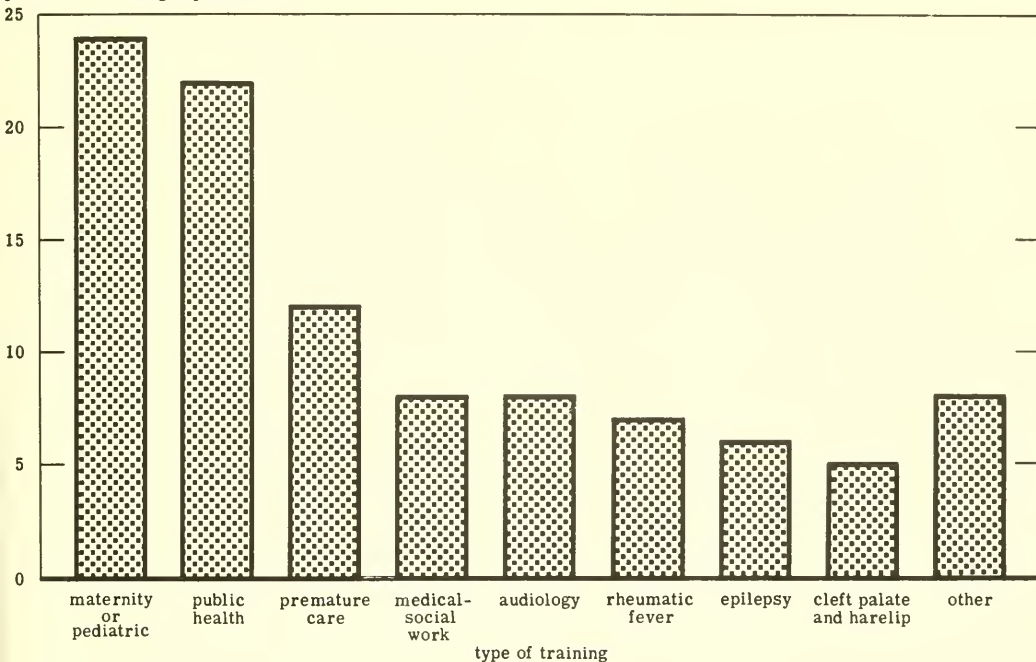
SOME State agencies providing Maternal and Child Health and Crippled Children's Services seek to improve their work by sponsoring postgraduate training for physicians, nurses, medical social workers, and other professionals. The amount spent for training is usually quite small in comparison with expenditures for services.

The largest expenditures for training under both the Maternal and Child Health and Crippled Children's programs are made from special project funds. During the fiscal year 1955, almost \$1 million was spent to finance 22 special Maternal and Child Health and 14 special Crippled Children's training projects. Projects providing training in public health, maternity, pediatric, or premature care, receive most of the money, but a variety of other training projects were also in operation.

Special project training is usually given at a university or special training center. Most of the funds are spent by the project for salaries, equipment, and various other project expenses, but some of it is used for fellowships.

SOME PROFESSIONAL WORKERS ARE GIVEN POSTGRADUATE TRAINING THROUGH SPECIAL PROJECTS IN MATERNAL AND CHILD HEALTH OR CRIPPLED CHILDREN'S AGENCIES

percent of training expenditures

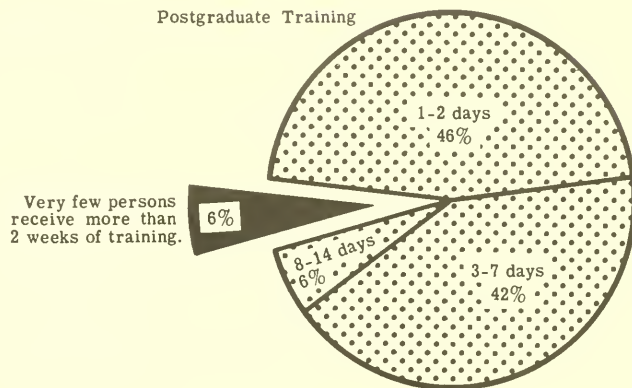
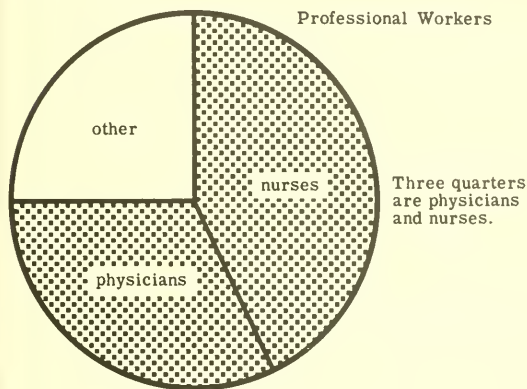


MOST Maternal and Child Health and many Crippled Children's agencies use a small portion of their regular program funds (Federal, State, and local) to finance or help finance short institutes, refresher courses, and in-service training programs for groups of professional workers. Many of the programs also spend money for longer and more formal postgraduate training of a few individuals, at universities and colleges.

In 1954, almost 7,000 doctors, nurses, and other professional workers received instruction that was wholly or partly financed by the States through their Maternal and Child Health and Crippled Children's program funds. Most of them were employees of State and local public health agencies, but physicians in private practice and many others whose activities related in some way to carrying out maternal and child health or crippled children's services also participated. Most of them attended special institutes and refresher courses that lasted only a few days. Only 400 persons received training in excess of two weeks.

About two-fifths of the 6,300 persons participating in the maternal and child health training programs received instruction in obstetrics or some other subject directly related to maternity and newborn infant care; the rest studied premature care, pediatrics, school health, dental care, nutrition, and various other subjects. About 450 persons received training through crippled children's programs, relating to rheumatic fever, cerebral palsy, pediatrics, orthopedics or physical and occupational therapy.

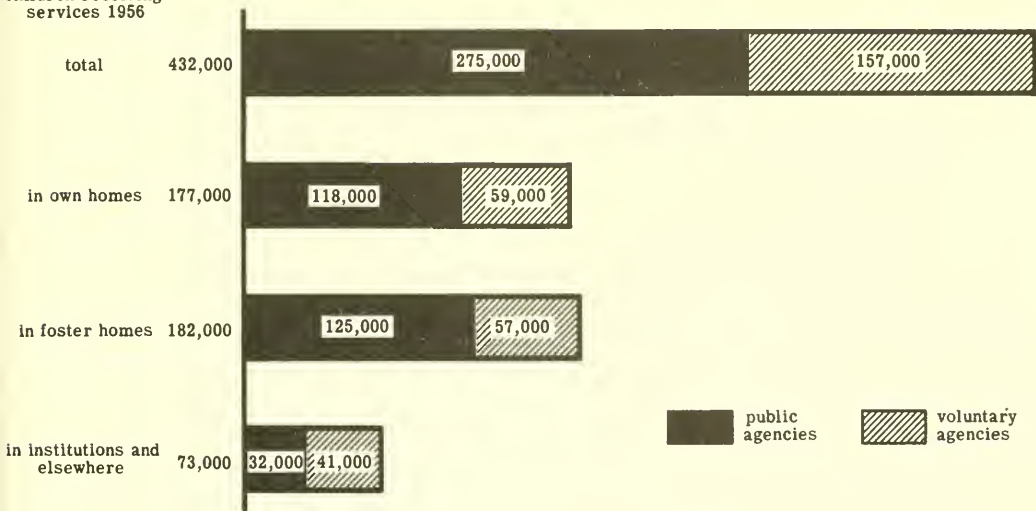
MANY PROFESSIONAL WORKERS RECEIVE POSTGRADUATE TRAINING UNDER THE REGULAR MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S PROGRAMS



CHILD welfare casework service by a public or voluntary agency is designed to protect and promote the social and emotional well-being of children. In 1956 on any one day seven out of every one thousand children in the United States were receiving such services from a child welfare casework agency. Some of these children were living in their own homes, others were in foster family homes or institutions. Large numbers of children are being served by the programs of public assistance, juvenile courts, medical and psychiatric hospitals and clinics, day care centers and institutions other than those included in the foregoing figures

CHILD WELFARE CASEWORK IS SERVICE TO INDIVIDUAL CHILDREN AND THEIR PARENTS

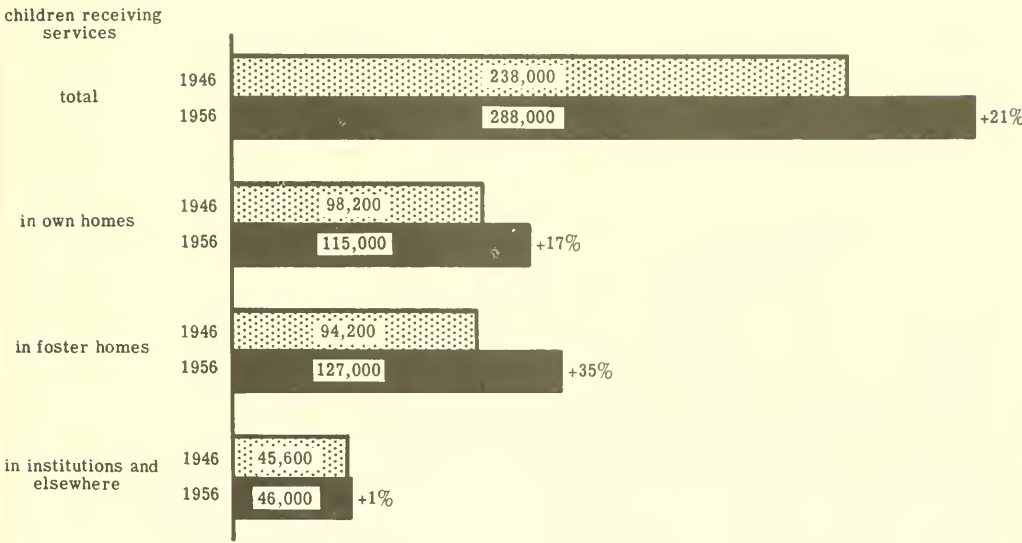
children receiving
services 1956



This chart does not include children receiving services from staff members of institutions, day care centers, juvenile courts, probation departments, or most children in families receiving public assistance.

STATE and local public welfare agencies have been providing child welfare casework services to an increasing number of children. The home life of many children could be sustained and enriched if more child welfare casework services were available. The general well-being of many children would be furthered if local communities had more homemaker services and access to more facilities, such as residential treatment centers for emotionally disturbed children.

INCREASING NUMBERS OF CHILDREN ARE RECEIVING CHILD WELFARE CASEWORK SERVICES FROM STATE AND LOCAL PUBLIC WELFARE AGENCIES



This chart does not include children receiving services from staff members of public institutions, day care centers, juvenile courts, probation departments, or most children in families receiving public assistance.

INFORMATION from 40 States shows that the number of children receiving child welfare casework services from public welfare agencies increased on the average 18 percent from 1946 to 1955 but the population under 21 in these States increased 32 percent in the same period.

There has been increasing cooperation between public and voluntary agencies, and increasing numbers of children have been served by each. In 38 States reporting comparable data, between 1952 and 1955 the increase was 9 percent for public agencies and 5 percent for voluntary agencies. But there are large numbers of children requiring service who are being reached by neither program.

STATE AND LOCAL PUBLIC CHILD WELFARE PROGRAMS ARE EXPANDING BUT NOT FAST ENOUGH TO KEEP UP WITH THE INCREASE IN THE CHILD POPULATION

index (1946=100)

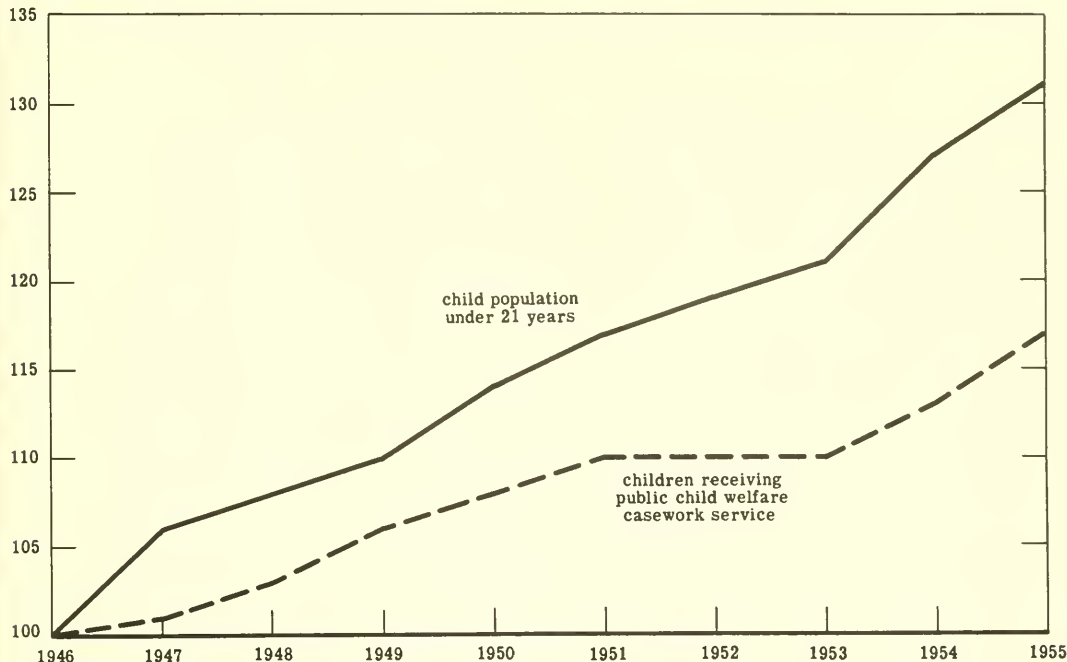
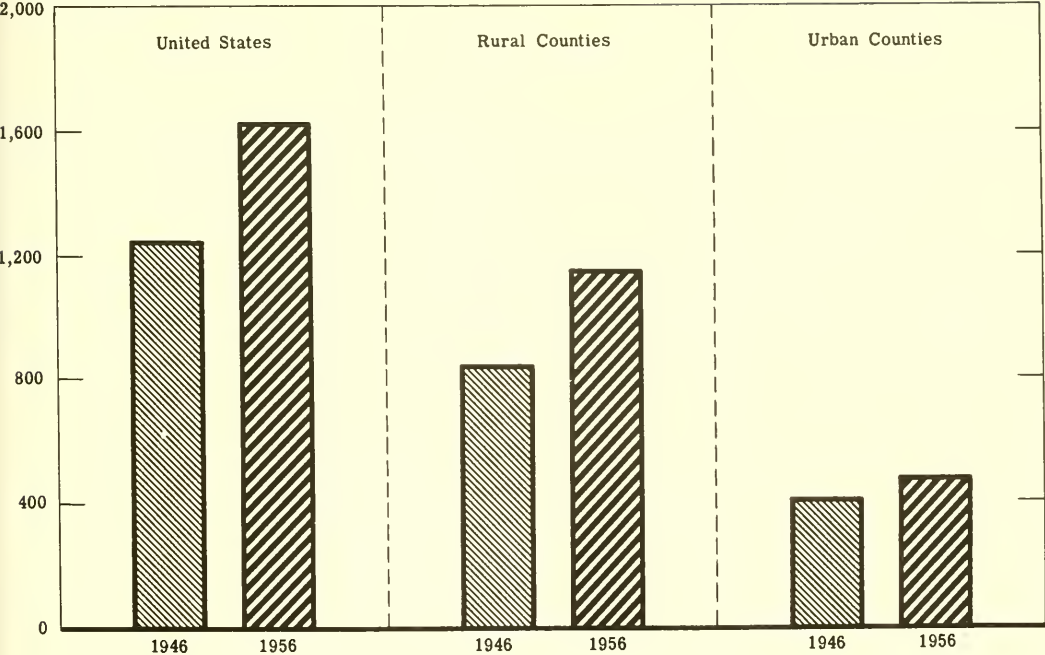


Chart 31

THE number of rural counties with access to the services of full-time child welfare workers employed by State or local public welfare agencies in 1956 was 37 percent greater than in 1946. Ideally all social services obtainable through public welfare agencies should be available for all people who need them, in all parts of the country. In 1956 only 1,623 of the 3,187 counties of the Nation had the services of a worker giving full time to child welfare work.

MORE COUNTIES NOW HAVE THE SERVICES OF A FULL-TIME PUBLIC CHILD WELFARE CASEWORKER

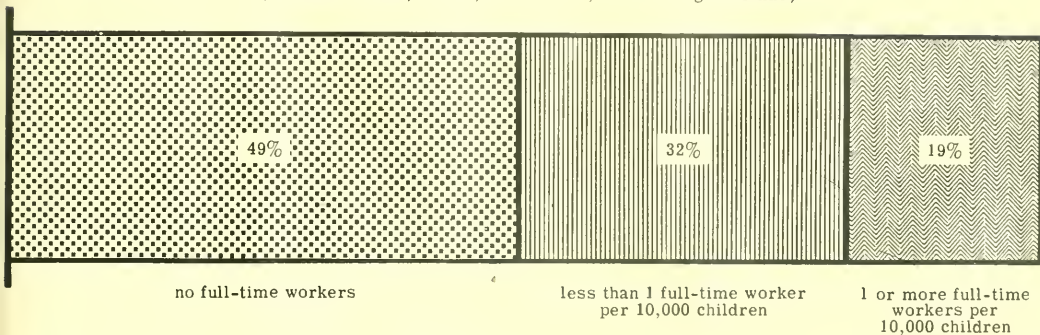
number of counties
2,000



WHILE progress has been made since World War II, particularly in rural counties, many areas of the country are still without full-time public child welfare caseworkers.

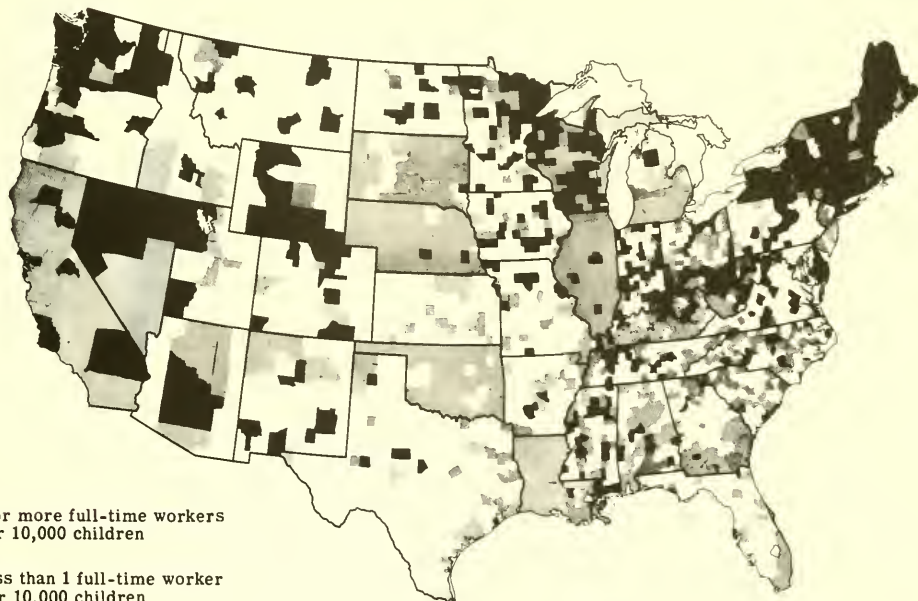
MOST COUNTIES ARE STILL UNDERSTAFFED IN PUBLIC CHILD WELFARE CASEWORKERS

percent of counties in the United States
(includes Alaska, Hawaii, Puerto Rico, and the Virgin Islands)



THERE is considerable variation both among States and within the counties of a single State in provisions for public child welfare services. In many counties child welfare casework services are available from voluntary child caring agencies and institutions, but this information is not available on a county basis.

OVER HALF OF THE COUNTIES IN THE NATION ARE SERVED BY A FULL-TIME PUBLIC CHILD WELFARE CASEWORKER



- 1 or more full-time workers per 10,000 children
- less than 1 full-time worker per 10,000 children
- no workers

1954 data incomplete for California, Kentucky, Maryland and Pennsylvania

EFFECTIVE social service to children requires the competence developed through professional education. Federal funds may be used by States to improve the quality of their programs for children by financing graduate training for their child welfare staff.

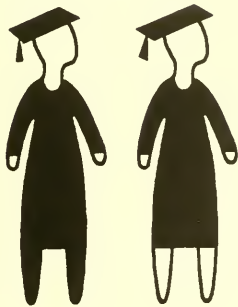
Child welfare caseworkers require a high quality of graduate education, as do their technical and administrative supervisors and consultants.

More than one quarter of the social workers in the public child welfare programs now are professionally trained. There has been definite progress in recent years in the States and localities in raising the educational level. Between 1950 and 1955 the number of child welfare workers with full training in social work rose from 19 to 28 percent of the total. It is also encouraging that most of the untrained workers meet the educational requirements for entrance into professional training.

MOST PUBLIC CHILD WELFARE WORKERS NEED MORE PROFESSIONAL TRAINING

THE STANDARD

Every employee in a professional position in a public child welfare agency should have a Master's degree from an accredited school of social work.



The situation in 1955
Of 4,871 full-time employees in professional positions in public child welfare agencies, about whose education information was available:

Needing to move toward the standard

1,905 (39%) had no graduate study in an accredited school of social work. Most of them had a bachelor's degree, a necessary requirement for admission to such schools.

Moving toward the standard

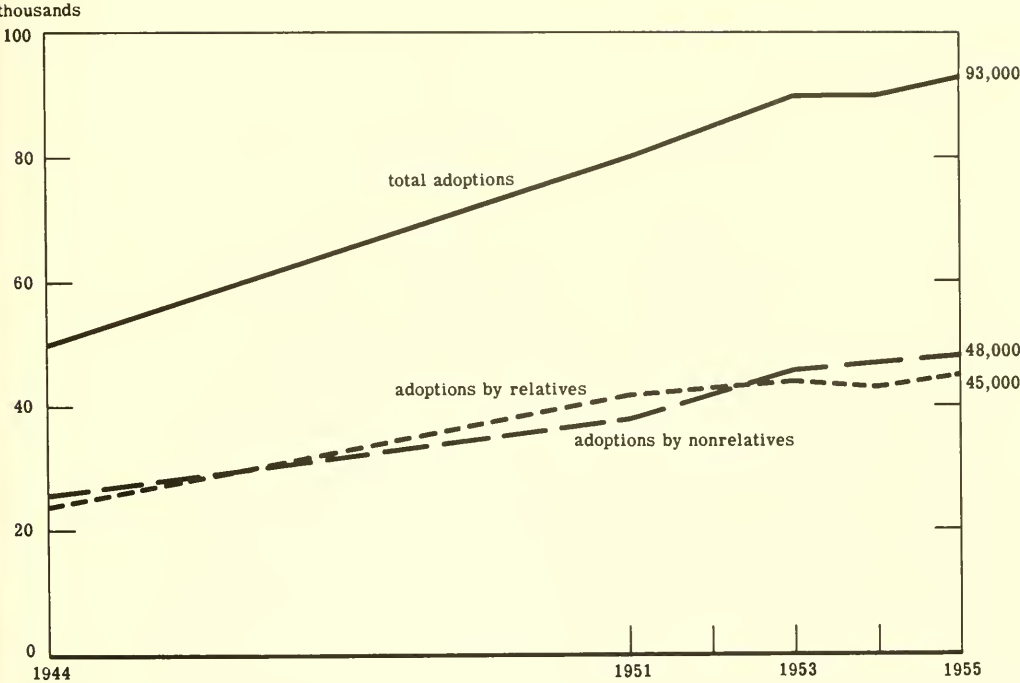
1,603 (33%) completed some graduate study in an accredited school of social work. Most of them had completed the first year of the two years required for the Master's degree.

Meeting the standard

1,363 (28%) had a Master's degree from an accredited school of social work.

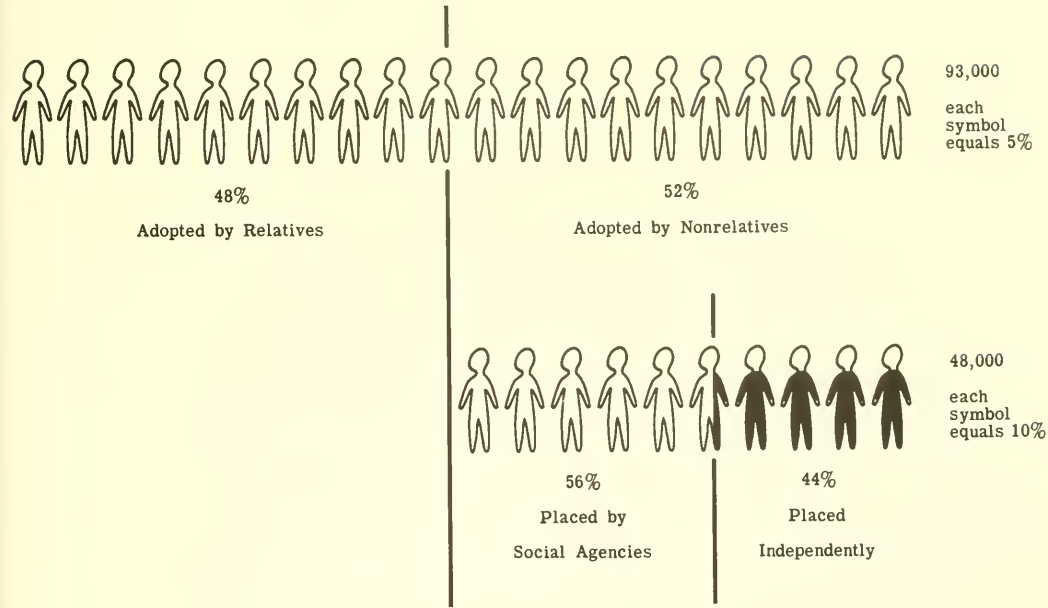
ADOPTION establishes a legal parental relationship between an individual and a person or persons who are not his natural parents. In 1955, an estimated 93,000 children were adopted. Less than half of these children were adopted by relatives, predominantly stepparents, and the remainder, about 48,000, were adopted by non-relatives.

ADOPTIONS BY NON-RELATIVES EXCEED ADOPTIONS BY RELATIVES



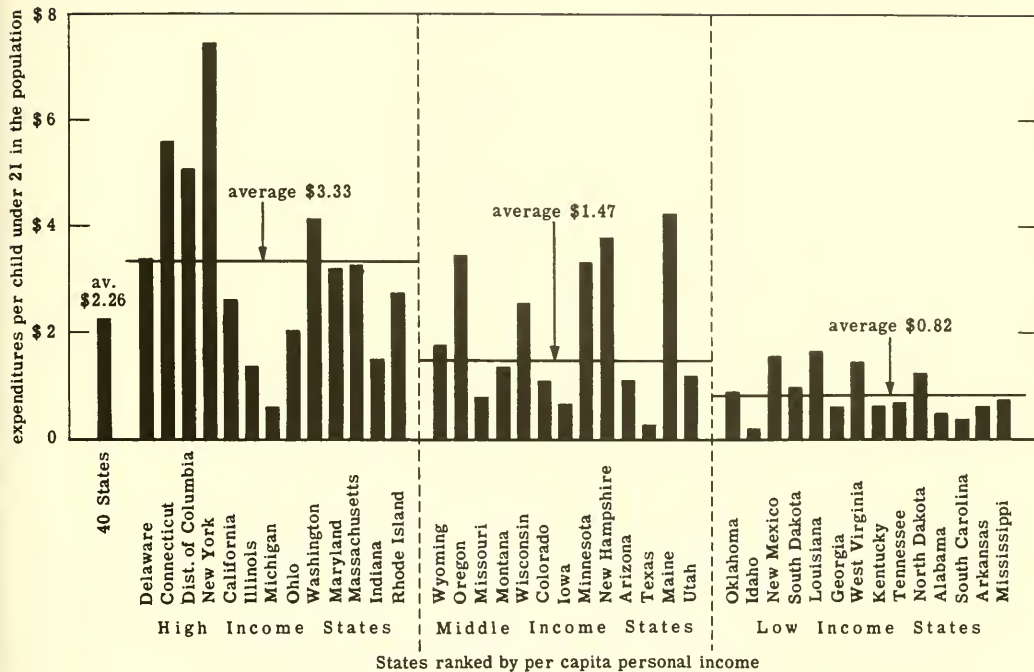
FOR the child whose relatives cannot adopt him, placement by an authorized social agency with non-relatives for adoption provides protection for the child, the adopting parents, and the natural parents. Social agencies now participate in placing the majority of the children who are adopted by non-relatives.

SOCIAL AGENCIES PROVIDE PROTECTIONS FOR THE
MAJORITY OF CHILDREN ADOPTED BY NON-RELATIVES



LIMITATIONS in State and local financial resources have much to do with variations in the scope and quality of public child welfare services. In 1955 in the lowest income States, expenditures per child from Federal, State and local funds for child welfare services were only one-fourth as much as in the highest income States in relation to the child population.

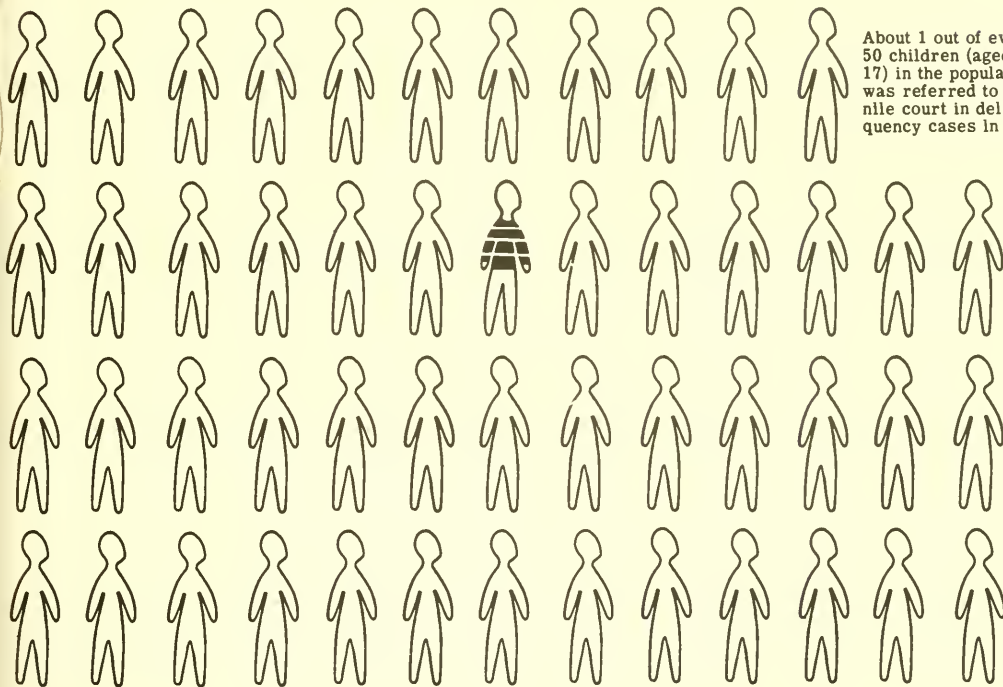
LOW INCOME STATES SPEND LESS FOR PUBLIC CHILD WELFARE SERVICES



THE number of children referred to juvenile courts for delinquency each year is only about 2 percent of the Nation's children. About three times this many come to the attention of police for misbehavior. Many more children whose behavior is similar either are undiscovered or come to the attention of agencies other than those involved in law-enforcement.

All communities find that the problem of providing adequate treatment services to these children is a serious one.

CHILDREN APPEARING IN JUVENILE COURT FOR REASONS OF DELINQUENCY CONSTITUTE ONLY A SMALL PERCENTAGE OF ALL CHILDREN



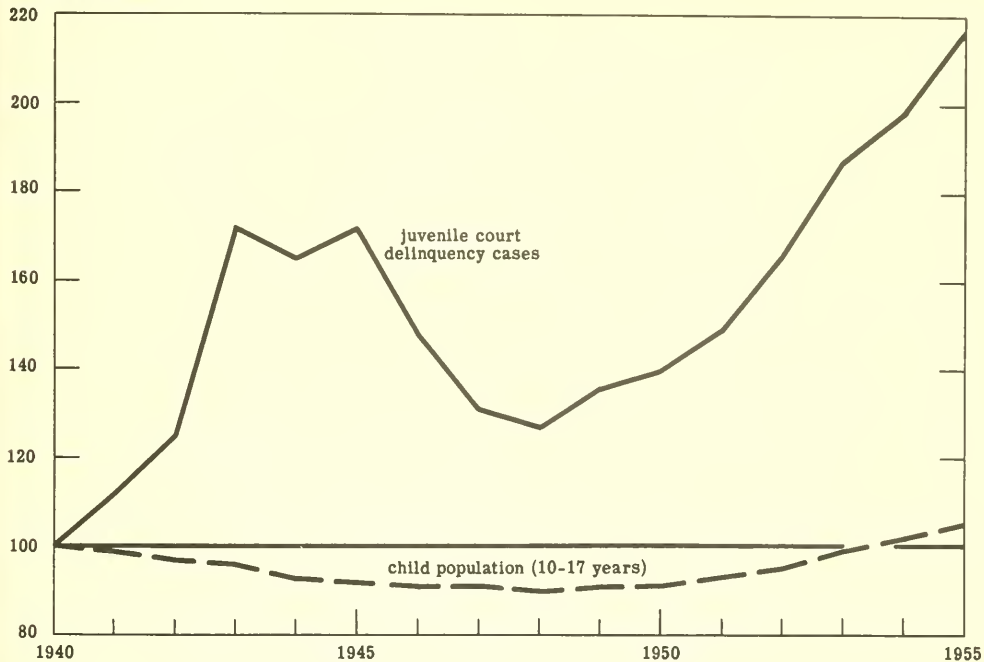
About 1 out of every 50 children (aged 10-17) in the population was referred to juvenile court in delinquency cases in 1955.

THE child population aged 10-17 years is expected to increase by 50 percent in the next decade.

The number of delinquency cases referred to courts has been rising during recent years and may continue to increase, even if the rate remains the same or drops slightly. Increase in numbers of cases will require more services and facilities and more staff to attack the problem of juvenile delinquency.

THE NUMBER OF DELINQUENCY CASES IN JUVENILE COURTS HAS BEEN RISING

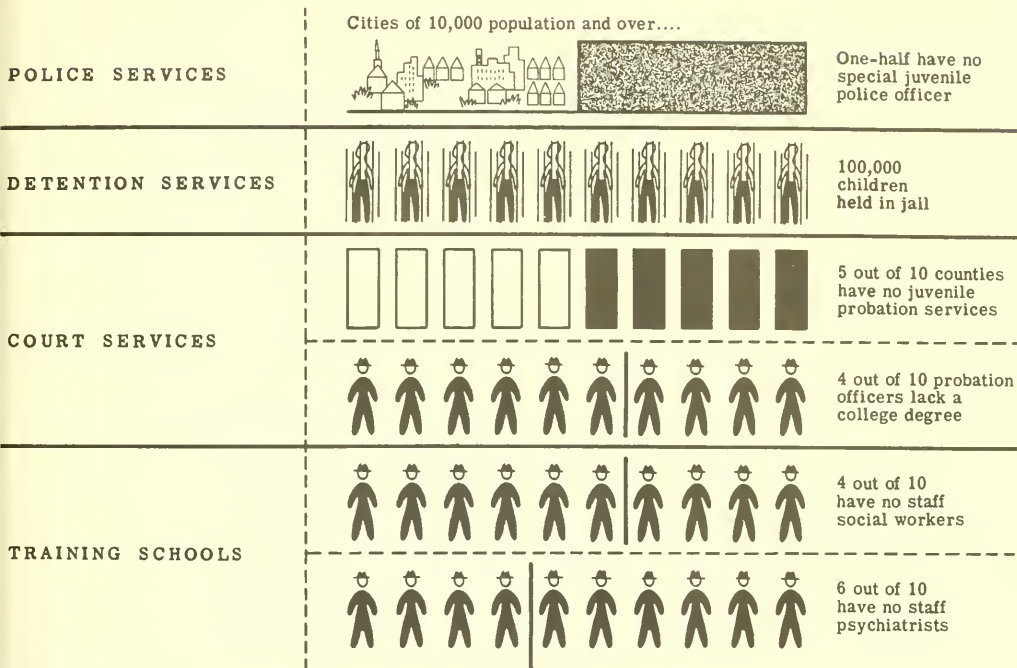
Index (1940 = 100)



PROGRAMS dealing with delinquents are deficient in two respects: (1) there are not enough of them and (2) those available do not have enough adequately trained personnel to provide the right kind of service.

When staff and facilities are not available or are inadequate, it is not surprising that about one-third of the delinquent children who come to the attention of the juvenile courts each year have been there before. With the expected increase in delinquency because of large increase in the child population, our already inadequate resources and facilities will be even more inadequate.

GAPS IN PROGRAMS FOR DELINQUENTS ARE WIDE



TODAY all children are living in a fast moving highly complicated world—a world full of problems: the atomic age, the draft, high mobility and migration, automation, a world of widespread social and technological change, a world of uncertainties. Many are bewildered, troubled, angry, bitter or cynical about their present circumstances and future prospects.

Among other assumptions about a world of uncertainties is the assumption that delinquent behavior in youngsters may be a characteristic reaction. Yet not all children become delinquent. On the contrary only a small proportion do.

Wide-spread efforts are essential to find out why some children become delinquent and others do not, although living under apparently similar circumstances. Research is our most promising way to more effective prevention of juvenile delinquency.

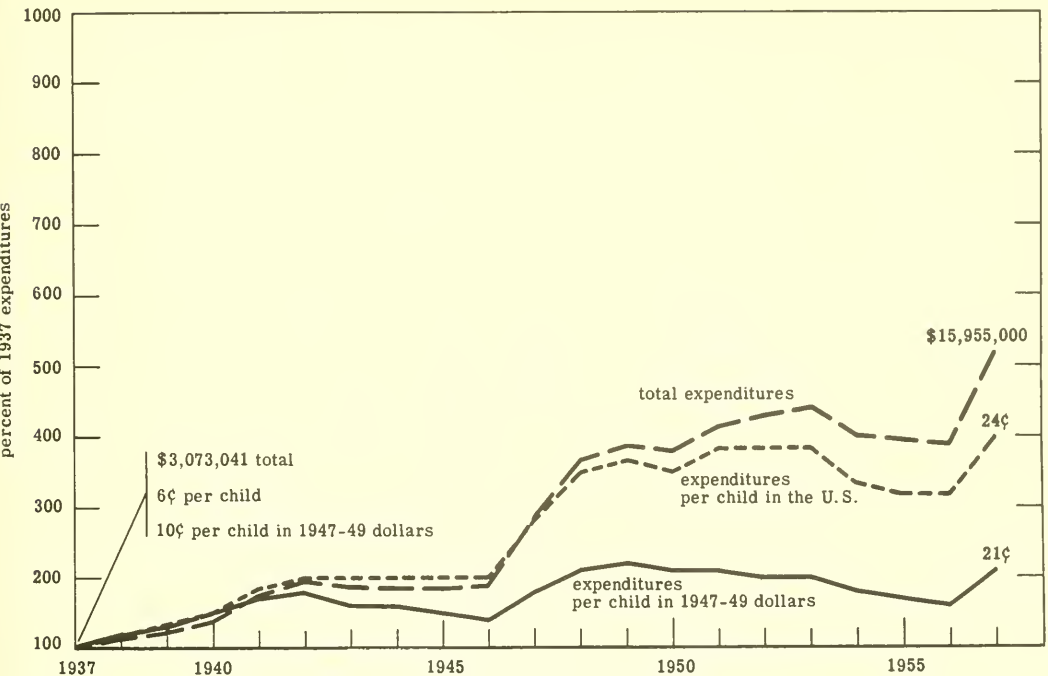
To help meet this need, the Children's Bureau conducts studies and collects data on delinquency; consults with social agencies and universities on problems of research in this field; sponsors conferences on needed research; and through its clearinghouse of research relating to children, reports on current studies and their findings

THE CHILDREN'S BUREAU RESEARCH PROGRAM TAKES A CLOSER LOOK AT DELINQUENCY



ALTHOUGH the amount of Federal funds spent on maternal and child health services has increased steadily over the years, the proportion of the total cost of such services that is carried by the Federal Government has decreased. Between 1940 and 1954 the combined Federal, State and local expenditures for maternal and child health services increased from \$11.5 million to \$40.5 million. In 1940 the Federal share of the combined budget amounted to 48 percent; in 1954 the Federal contribution was 26 percent.

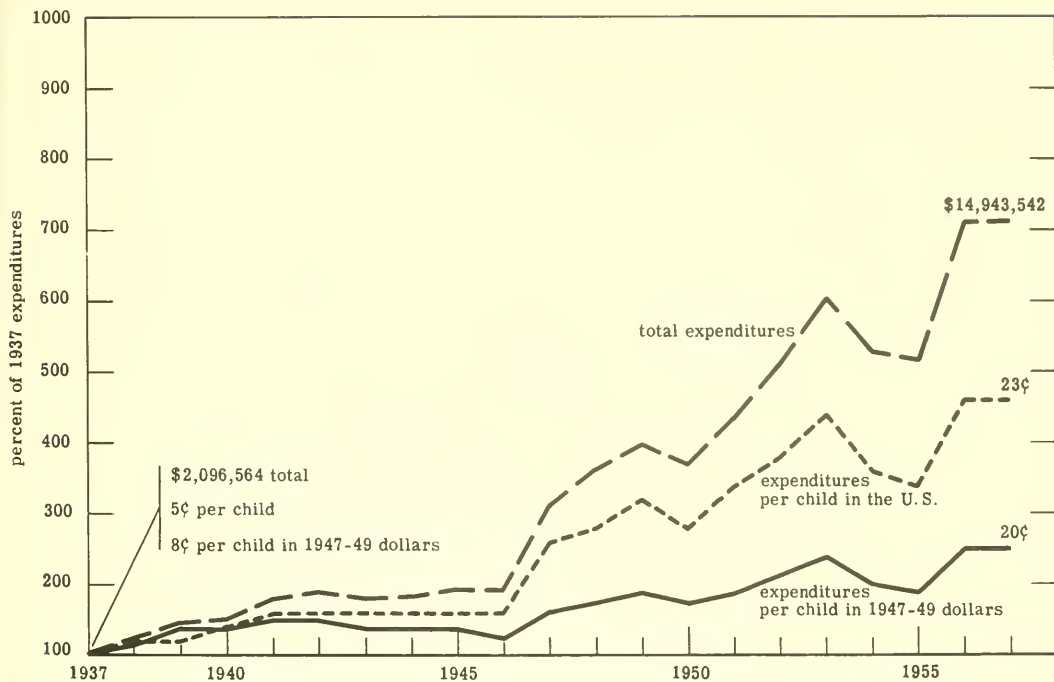
STATE EXPENDITURES OF FEDERAL FUNDS: MATERNAL AND CHILD HEALTH SERVICES



Financial Data

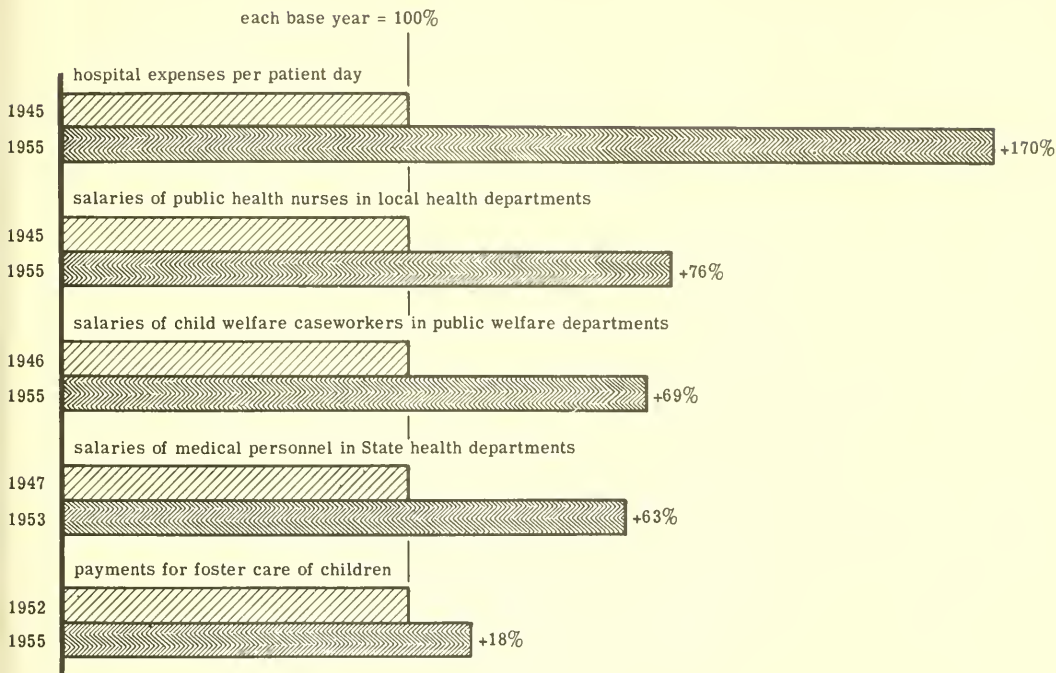
EACH year more than a quarter of a million children receive services from pediatricians, orthopedists, physical therapists, public health nurses, medical social workers, occupational therapists, or other trained people working through State crippled children's agencies. The Federal Government helps States in providing these services for crippled children through grants, half of which must be matched dollar for dollar by the States.

STATE EXPENDITURES OF FEDERAL FUNDS: CRIPPLED CHILDREN'S SERVICES



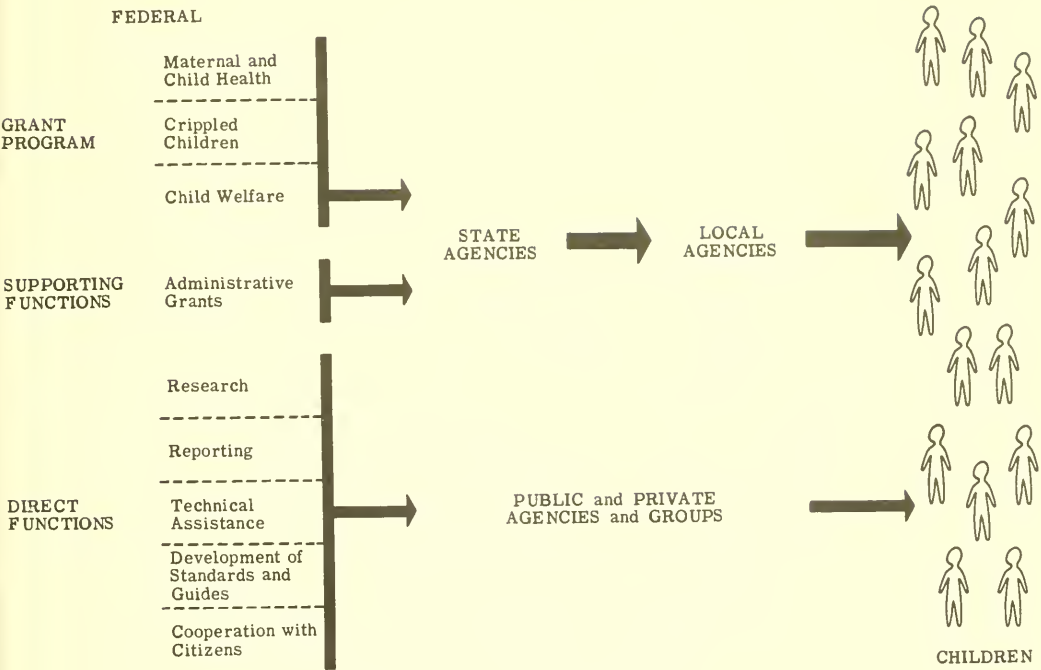
PART of the additional total expenditure by the States goes for higher salaries and increased costs of materials. Higher salary levels show up quickly because the greater part of Federal funds expended by States are applicable to professional salaries. A relatively small proportion of Federal funds is spent for board of children in foster care and for the hospitalization of crippled children. Increases in these costs are related to a mounting price level. With increases in salary levels, service and equipment costs, the increased expenditures may not indicate that more services are available to more children.

CHILDREN'S HEALTH AND WELFARE SERVICES COST MORE



ALWAYS responsive to the changing environment into which children are born and in which they mature, the Children's Bureau has stimulated many different activities since its creation in 1912. The intermeshing, interlocking purposes of the Bureau today are: to administer the money that the Congress appropriates each year to aid the States in building these programs for the health and welfare of their children; to assemble facts needed to keep the country informed about children and about matters adversely affecting their well-being; to recommend measures believed to be effective in advancing the wholesome development of children and in preventing and treating the ill effects of adverse conditions; and to give technical assistance to citizens and to voluntary and public agencies and organizations in improving the conditions of childhood.

THE CHILDREN'S BUREAU



The Children's Bureau, U. S. Department of Health, Education, and Welfare





children *and* youth *their Health and Welfare*

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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